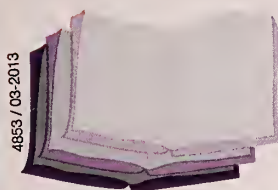


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A FRAMEWORK FOR THE RESPONSE TO ALCOHOL AND DRUG PROBLEMS IN ONTARIO

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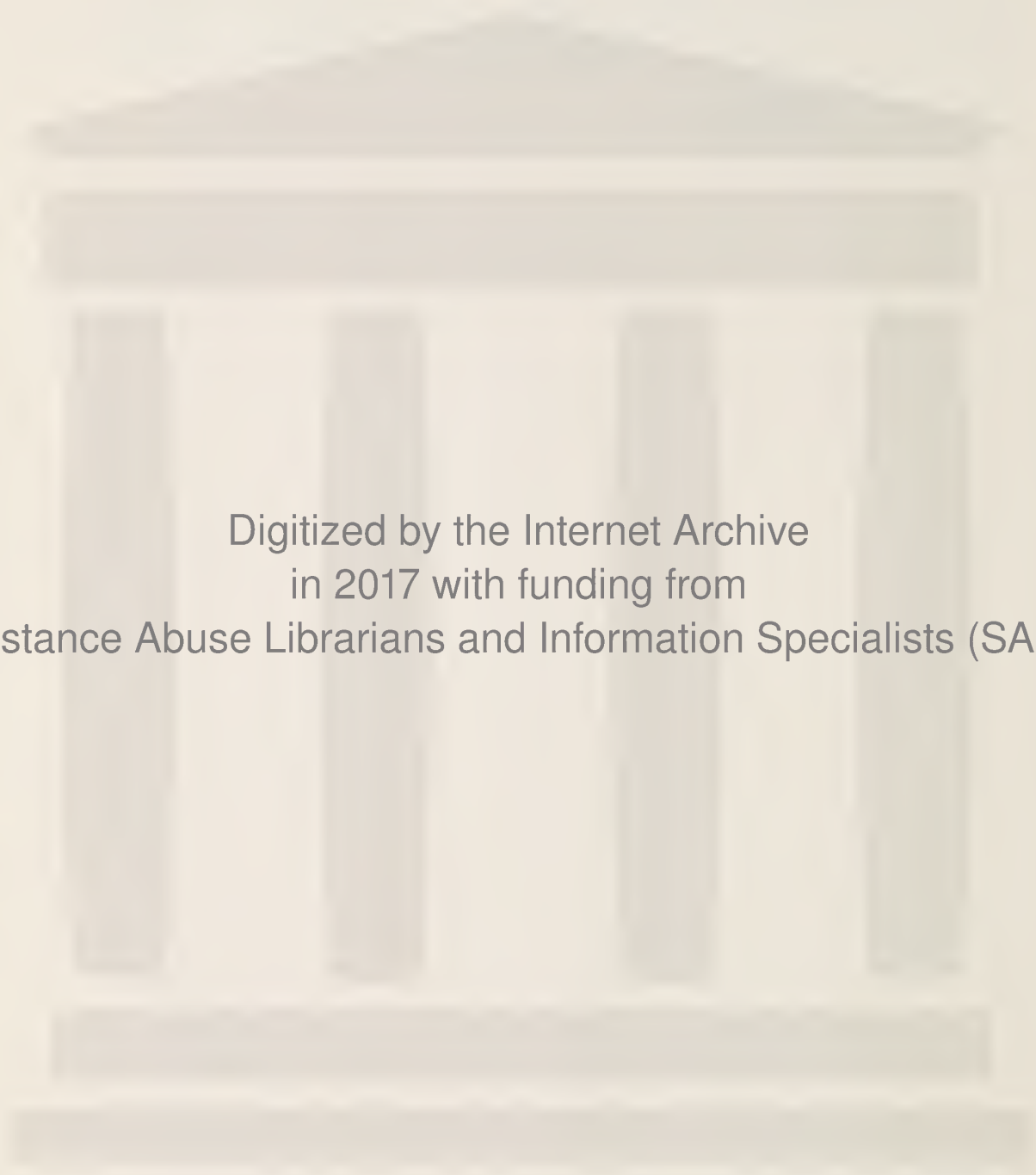
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ISBN 0-7729-4788-9
2500 11/89

Cette publication est également disponible en français.



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Ontario

Ministry Ministère
of de
Health la Santé

6th Floor, 15 Overlea Blvd.
Toronto, Ontario M4H 1A9

Tel: (416) 963-0614

December 1988

The Honourable Elinor Caplan, M.P.P.
Oriole
Minister of Health
10th Floor, Hepburn Block
Queen's Park
Toronto, Ontario
M7A 2C4

Dear Mrs. Caplan:

On behalf of the Working Group for Alcohol and Drug Problems, I am pleased to submit our report, "A Framework for the Response to Alcohol and Drug Problems in Ontario".

This report is an important planning framework which will provide the tools for local communities to plan and develop a comprehensive range of services for alcohol and drug problems. This report will provide District Health Councils with a base to formulate a three year Alcohol and Drug Services Plan to ensure that new services recommended are those that are the most effective and efficient for local needs.

In developing this report, focus group meetings were held with representatives from District Health Councils and Alcohol and Drug Programs to obtain feedback on the framework. The input provided by these individuals was tremendously valuable to the working group.

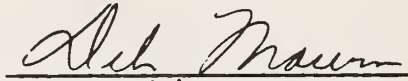
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The working group would also like to commend the Ministry for the recent initiative that specifically targetted youth and incorporated health promotion and prevention in its funding criteria. The working group supports the concept of allocating 15 percent of new funding each year for health promotion and prevention to create a better balance between health promotion and treatment initiatives.

We strongly support the Premier's Council on Health Strategy in their continuing efforts to define health-related public policy and address provincial policy issues. We suggest that their endeavours should also encompass concerns related to alcohol and drug use and abuse.

We recognize that further work is required to develop a total integrated strategy for the Province in alcohol and drug abuse. In this regard, the Addiction Research Foundation has expressed interest in further developing the "Drug" side of the continuum as new data becomes available.

Yours sincerely,


Debi Mauro
Chairperson

ALCOHOL AND OTHER DRUG ISSUES WORKING GROUP MEMBERS

Mr. C.A. Bigenwald
Executive Director
Health Programs
8th Floor, Hepburn Block
Toronto, Ontario
M7A 1R3
(Previously Executive Director, D.H.C. Program)

Ms Janet Doering
Health Programs
8th Floor, Hepburn Block
Toronto, Ontario
M7A 1R3
(Previously Area Planning Assistant, D.H.C. Program)

Mr. Yale Drazin
Director
Drug Programs Branch
6th Floor, 7 Overlea Blvd.
Toronto, Ontario
M4H 1A8
(Previously Director, Mental Health Planning Branch)

Dr. Myrna Francis
Director
Health Promotion Branch
Ministry of Health
700 Bay Street, Suite 1401
Toronto, Ontario
M5G 1Z6

Mr. S. Handler
Manager
Social Support Unit
Family Support Branch
Ministry of Community and Social Services
4th Floor, Hepburn Block
Toronto, Ontario M5G 1Z6

Ms Sheila Latimer
Project Co-ordinator
Teaching and Speciality Hospitals Branch
7th Floor, 15 Overlea Boulevard
Toronto, Ontario M4H 1A9

Ms D. Loranger
Director
Community Health Programs Branch
6th Floor, 15 Overlea Boulevard
Toronto, Ontario
M4H 1A9

Dr. Peter Loranger
Prevention and Health Promotion
Programs Division
Addiction Research Foundation
33 Russell Street
Toronto, Ontario M5S 2S1

Ms Debi Mauro
Executive Director
District Health Council Program
6th Floor, 15 Overlea Blvd.
Toronto, Ontario M4H 1A9
(Previously Director, Community Mental Health Branch)

Dr. Sheldon Pearlman
Associate Director
Clinical Institute Division
Addiction Research Foundation
33 Russell Street
Toronto, Ontario
M5S 2S1

Dr. James G. Rankin
Physician in Chief
Clinical Institute
Addiction Research Foundation
33 Russell Street
Toronto, Ontario
M5S 2S1

Mr. John La Rocque
Director
Community Services Division
Addiction Research Foundation
33 Russell Street
Toronto, Ontario
M5S 2S1

Special thanks to Dr. Brian Rush and Mr. Robert Simpson.

1. Purpose

This statement provides a framework within which communities at the district level can plan and implement programs, services, and policies to reduce the incidence, prevalence, and severity of problems associated with the use of alcohol and other drugs.*

2. Alcohol

Alcohol, the most widely used drug in Ontario, is consumed by approximately 80 percent of the population 15 years of age and over. Moreover, alcohol is responsible for more problems among Ontario residents than any other drug. Most drinkers, however, consume alcohol in ways which are unlikely to harm themselves or others. Within this broad perspective, the overall goals with respect to alcohol consumption are therefore:

- (a) to increase the acceptability and desirability of abstention;
- (b) to increase, among drinkers, the proportion whose consumption poses little threat to their health and social well-being;
- (c) to decrease, among drinkers, the proportion whose consumption is potentially harmful to their health and social well-being; and
- (d) to effectively and efficiently address problems resulting from the consumption of alcohol.

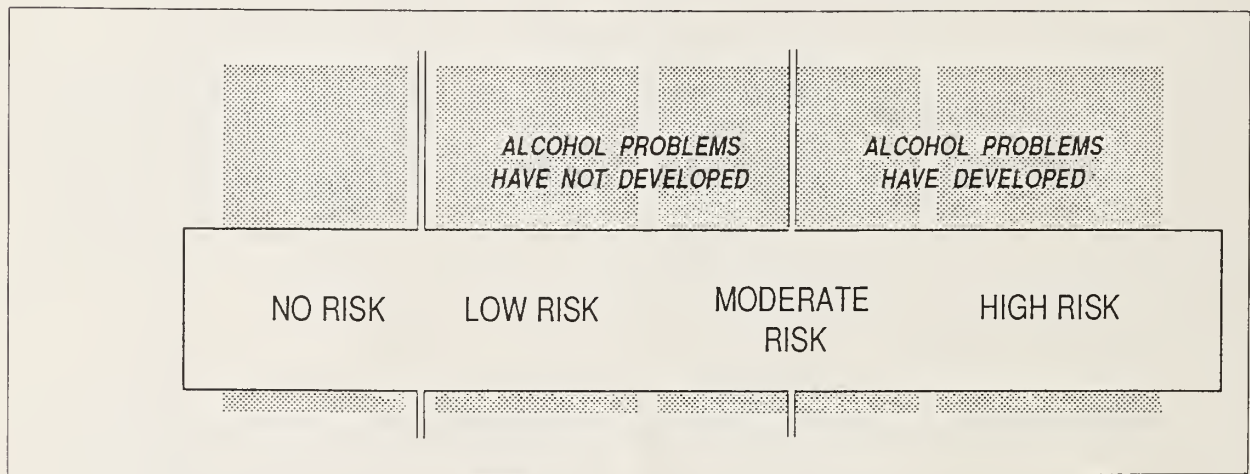
* Alcohol is, of course, a drug but is identified separately in this statement in recognition of its dominant role as a drug of dependence. Accordingly, the term "drug" refers to a range of other substances, including illicit and prescription drugs, and inhalants: tobacco and caffeine are specifically excluded.

2.1 A Continuum of Risk

The likelihood of an individual experiencing alcohol problems is directly related to the amount of alcohol consumed (levels) and the conditions under which it is consumed (contexts). Certain drinking levels and contexts have a low association with problems, and are known as "low risk" behaviours. Each of these behaviours has a "risk" counterpart, which has a higher association with problems.* A list of the most common "low risk" behaviours and their "risk" counterparts is found in Appendix A.

As drinkers cross "low risk" thresholds, the likelihood of their experiencing problems increases. In this context, risk is an expression of probability. The level of risk increases with both the extent to which the drinker exceeds the "low risk" thresholds and the frequency of these departures. Accordingly, risk can be expressed along a continuum, as depicted in Figure 1.

FIGURE 1
THE RISK CONTINUUM FOR ALCOHOL PROBLEMS



*

In addition to the direct risks associated with consumption practices, a number of other forms of risk are frequently cited regarding alcohol problems. These generally refer to a range of predisposing characteristics such as being a member of a particular cultural group or the child of a problem drinker. These correlates represent an indirect or secondary level of risk, since they place the individual "at risk of engaging in risk consumption". Alcohol problems will not occur, of course, until one or more risk consumption practices have been adopted.

The risk continuum is a conceptual tool designed for planning purposes. In actual populations, drinkers are constantly changing their drinking patterns and, in so doing, can migrate from one category to the next. Also, the development of alcohol problems is not as simple as crossing a line: alcohol-related problems evolve slowly and progressively over time.

The risk continuum makes it possible to define a series of program and service categories into which any population can be separated. Four categories are identified: No Risk, Low Risk, Moderate Risk, and High Risk. For planning purposes, each can be considered a separate target group characterized by its relative level of risk. Programs and services can then be developed in line with each category and shaped by a distinct set of objectives and strategies.

In addition to identifying the four risk categories, the Risk Continuum aligns each with the presence or absence of alcohol problems. This recognizes the substantial differences between the programs and services directed toward people who are experiencing alcohol problems and those directed toward people who are not.

The range of alcohol problems associated with risk consumption is broadly defined and includes psychosocial problems, frequently marked by a deterioration in important relationships and the ability to interact with others in acceptable ways; legal problems, such as impaired driving or assault charges, in which alcohol plays a direct or contributing role; and health problems, which range from acute episodes resulting from alcohol-related accidents, to chronic diseases, such as cancer or cirrhosis, that are associated with prolonged heavy consumption. Finally, alcohol problems extend to the phenomenon of dependence, a condition which has traditionally been associated with the concept of alcoholism.

At the left end of the continuum, the No Risk category includes the 20 percent of Ontario adults who do not drink alcohol. Most of the population under 15 years of age does not drink and fits into this category. For program planning purposes, these people are considered to be free of

alcohol problems due to their choice not to drink.* A similar rationale applies to the Low Risk category, which is also aligned with the absence of alcohol problems, and includes people whose drinking has a low association with problems. For planning purposes, the vast majority of these people can be considered problem-free.** It is important to note, however, that the risk drinker population emerges from the No Risk and Low Risk categories, and in so doing creates the incidence rate for risk drinking. As described later, program and service strategies must incorporate this dynamic into a comprehensive response to alcohol problems.

People in the Moderate Risk category are drinking at levels and in contexts which are associated with elevated rates for alcohol problems. Despite increased levels of risk or probability, some of these people will not develop problems, while others will. Accordingly, the Moderate Risk category is split in two, with one sub-category aligned with the presence of alcohol problems, and the other with the absence of alcohol problems. This distinction recognizes the need for different types of programs and services for people in each sub-category.

* The fact that non-drinkers can be affected by the drinking of others should not, however, be overlooked. For example, an individual with drinking problems can have a substantial impact on the physical and psychosocial health of a spouse or children. Similarly, the victims of drinking drivers can be non-drinkers.

** A small proportion of drinkers in this category will experience alcohol problems. As discussed later, these people are included within the scope of a separate program strategy.

Finally, most people in the High Risk category will experience alcohol problems. The consumption of these people is destructive both to themselves and to those around them. Consequently, alcohol treatment systems have traditionally focused the bulk of their attention on this group.

2.2 The Distribution of Consumers

The population of Ontario is not evenly distributed across the four risk categories. Rather, most people are clustered into the No Risk and Low Risk categories, with increasingly smaller proportions found in the Moderate Risk and High Risk categories, respectively. This can be illustrated by examining the distribution of the Ontario adult population according to its "average level of consumption".

Essentially, the average level of consumption is a measure of the number of drinks^{*} a person usually has in the course of a week. It is a valid indicator of risk,^{**} and can be aligned with the risk categories as follows:

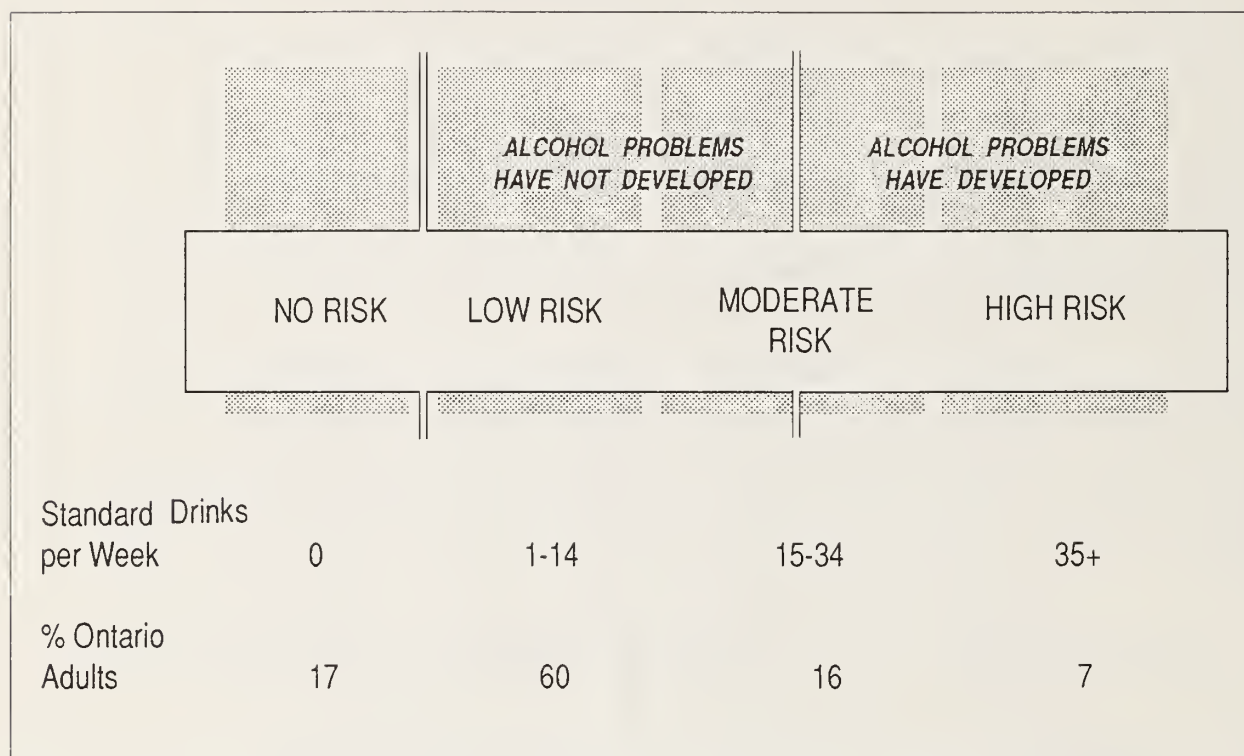
<u>RISK CATEGORY</u>	<u>AVERAGE CONSUMPTION (STANDARD DRINKS)</u>
NO RISK	No alcohol consumption
LOW RISK	1 - 14 drinks per week
MODERATE RISK	15 - 34 drinks per week
HIGH RISK	35 drinks or more per week

* A "drink" is a standardized unit which takes into account the type of beverage, be it beer, wine, or spirits.

** At the individual level, these risk levels will vary according to gender, lean body weight, and other factors. Despite individual variations, the risk categories are useful for planning purposes at the population level where variations are assimilated into overall averages.

The estimated distribution of the adult population in Ontario across these consumption ranges is shown in Figure 2.

FIGURE 2
THE DISTRIBUTION OF ADULTS IN ONTARIO
ACROSS THE RISK CONTINUUM

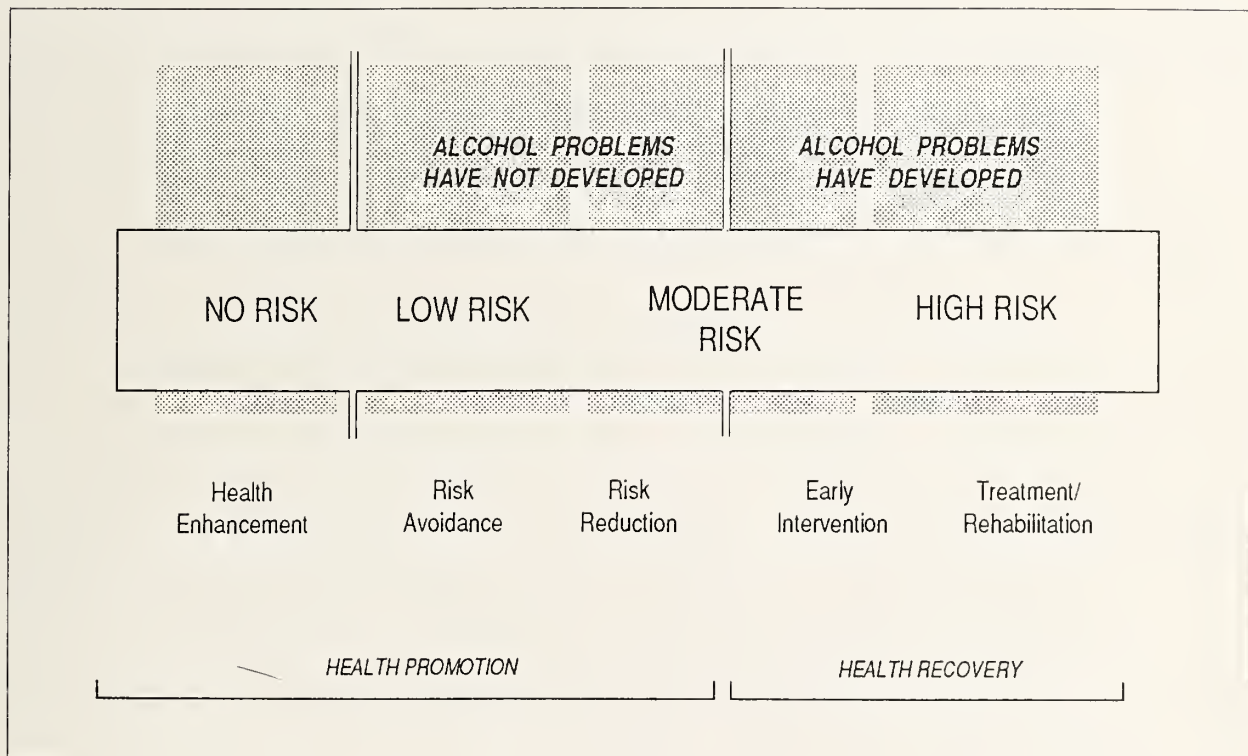


The above distribution suggests that approximately 77 percent of the adult population in Ontario is drinking at levels that have little or no association with alcohol problems. While this balance is somewhat reassuring, it must be tempered by the observation that more than one in five adults in Ontario is drinking at levels which represent a threat to health and social well-being.

2.3 Program and Service Strategies

The populations in each of the four risk categories can be matched to a specific strategy for the planning and implementation of programs and services. Figure 3 illustrates these strategies.

FIGURE 3
PROGRAM AND SERVICE STRATEGIES
IN RELATION TO THE RISK CONTINUUM



The following descriptions outline the essential features of each strategy.

Health Enhancement: This strategy is intended to increase the acceptability and desirability of abstaining from alcohol. In so doing, abstinence may be introduced, integrated, and promoted with a range of other healthy lifestyle practices

(such as those related to smoking, nutrition, and fitness) in the interests of health and social well-being.

Risk Avoidance: This strategy is aimed at drinkers in the Low Risk category (and "potential drinkers" such as secondary school students), and is intended to increase the likelihood that drinking will occur only at levels and in contexts which have a low association with health and social problems. It reinforces the adoption of low risk consumption, and may integrate it into a range of other positive lifestyle practices in the interests of health and social well-being.

Risk Reduction: This strategy is intended to reduce alcohol consumption to the Low Risk or No Risk categories before health and social problems develop among those drinkers in the Moderate Risk category who have yet to experience alcohol problems. It may be integrated with other risk reduction strategies (such as smoking cessation, weight loss, and nutritional counselling) in the interests of developing greater consistency among lifestyle practices.

Early Intervention: This strategy is intended, first, to identify drinkers in the Moderate Risk category who are experiencing alcohol related problems^{*}, and then, to intervene in order to effectively manage these problems and reduce consumption to Low Risk or No Risk levels.

* A small proportion of drinkers in the Low Risk category may be experiencing alcohol problems and can be included within this strategy.

Treatment/Rehabilitation: This strategy is intended to identify problem drinkers in the High Risk category, provide them with access to comprehensive assessment and match them to an appropriate mix of services, including follow-up. Treatment components are intended to prevent further deterioration and to stabilize the individual; rehabilitation components are intended to restore health and independent functioning to the extent possible.

Two other sub-strategies can be incorporated into the five described: Risk Containment and Harm Minimization. Risk containment is located within the risk avoidance strategy. It is aimed at people who are at risk by virtue of an indirect correlate such as being the child of a problem drinker. Essentially, the goal of this sub-strategy is to provide extra insulation to members of the target group in order to offset their predisposition toward the adoption of risk consumption practices.

The Harm Minimization sub-strategy is located within the treatment/rehabilitation strategy. It is aimed at people for whom the prognosis for recovery is poor, in either the short or longer term. Generally, these groups (for example, chronic skid row drinkers), experience a very low success rate in treatment/rehabilitation programs. In some instances, programs to minimize the harm experienced by these individuals might be a more realistic option. These programs can provide a safe and secure environment during periods of intoxication, attend to basic nutritional needs, and serve as an early detection mechanism for emerging disease, disability, or other problems. Clearly, the harm minimization is an option of last resort after all others have proved ineffective.

A comprehensive community system will incorporate programs and services consistent with each of the five identified program strategies. The actual nature of programs and services developed, as well as the ideal balance among strategies, is best planned at the local level. In this way, existing resources and local circumstances (such as physical

geography and population distribution) can be considered when plans are developed, and allowances can be made for the optimal array of programs and services to be identified in each district throughout the province.

2.4 Health Promotion Programs and Services

Health promotion programs and services are those which fall within the health enhancement, risk avoidance, and risk reduction strategies (see Figure 3). Their overall goals are to reduce the incidence of alcohol problems and to integrate No Risk and Low Risk drinking into a variety of healthy lifestyle practices.

A balanced community addictions system will include a range of health promotion programs and services. At the planning stage, it is important to select a cohesive array that collectively has the power to achieve positive impact over time.

Although there are many valid approaches to planning, the following four-step process illustrates how the task of selecting a local mix of health promotion programs and services might be accomplished. The process begins with the identification of key target groups within each of the three program strategies (health enhancement, risk avoidance, and risk reduction). For example, the following target groups might be identified within these categories:

- ° parents of young children
- ° primary and secondary school students
- ° children living with parents who are problem drinkers
- ° community college and university students
- ° young people in job search or job training programs
- ° employees in work sites throughout the district
- ° motor vehicle drivers
- ° members of the general public

The next step in the planning process is to develop objectives for each target group. Objectives can be of two types: ultimate or intermediate. The former describes a set of desired results or outcomes for the

target group. For example, a reduction in the prevalence of drinking and driving in the target group would constitute an ultimate objective within the risk reduction strategy. Alternatively, objectives can be employed to identify intermediate steps which reflect progress made by the target group toward these ultimate outcomes. For example, an intermediate objective might be to increase perceptions of the seriousness and undesirability of the consequences of impaired driving. In this illustration, the intermediate objective can be justified on the basis that it is a necessary step toward the realization of the ultimate outcome.

The third planning step is to identify those programs and services which, in the collective opinion of the planning committee, will best achieve the objectives selected. This step usually involves assessing the wide range of program and service materials available for use in Ontario communities. In the selection process, the planning committee should consider the known level of effectiveness of each program, as well as its suitability for adaptation and implementation in the local setting.

In the final step, the planning committee identifies those agencies, organizations or groups best able to implement each of the selected programs and services. This step will vary from one community to the next depending on the availability of community resources for program delivery, and on their willingness to accept responsibility for implementation. Accordingly, knowledge of community resources, in conjunction with strong and persuasive and negotiating abilities, are central to this final step.

There are no constraints or limitations on which community agencies or organizations are permitted to implement health promotion programs and services. One cluster of potential service providers can be identified by extending the focus of existing alcohol and drug treatment agencies to include a health promotion mandate. Their established expertise in the field may well equip them to accommodate an expansion of their role.

A second approach is to draw upon treatment agencies from outside the alcohol and drug network to deliver health promotion programs and services. This option might be supported by their generic expertise (in health education, for example) or by their access to certain target groups (such as adolescents, pregnant women, or people on prescription drugs). Under this option, family physicians, hospitals, clinics, and community health centres can all be considered as appropriate vehicles for implementation.

A third approach is to draw upon the wide range of community agencies and organizations that provide either health promotion services in areas other than alcohol and drugs or have a high degree of access to key target groups. Public health departments are a good example of the former in that they deliver a range of health promotion services in communities across Ontario. An example of a community resource that has a high degree of access to key target groups is the school system, where there are many opportunities to reach students through the delivery of programs and services. In addition to the school system, most communities have a variety of youth clubs, social agencies, and recreation facilities that can provide access to key target groups. In each case, it is a question of determining which intermediaries will provide the required access to the target group in ways that are likely to be credible and effective.

Health promotion initiatives are not limited to program and service options. Increasingly, there is a trend in Ontario toward the adoption of complementary health-oriented policies. In this context, policies can be understood as measures which are intended to impede the adoption of specific risk behaviours, and to promote or facilitate the adoption of "no risk" or "low risk" counterparts. Accordingly, health-oriented policies should be used to increase the overall impact of program and service initiatives. The converse is also true. Even well-designed programs and services can be effectively undermined by policies that explicitly or implicitly support the selection of risk options.

With respect to alcohol consumption, there are several health-oriented policies that can be adopted at the local level to complement health promotion programs and services. Some illustrative examples include:

- a) Municipal policies: these reduce illegal drinking in public places (such as parks and beaches), as well as drinking to intoxication in public facilities (such as recreation centres, municipal halls, and arenas);
- b) Campus policies: these are intended to limit average levels of consumption, drinking to intoxication, and impaired driving among post-secondary students;
- c) Licensed premise policies: these policies are intended to prevent intoxication and impaired driving among patrons of bars, taverns, restaurants, and other licensed premises;
- d) School policies: these allow school boards to develop and organize preventive, remedial, and disciplinary responses to alcohol and other drug use among students;
- e) Employer policies: these establish measures to educate employees about risk drinking thresholds, and to promote self-referrals to risk reduction and early intervention programs.

Policy initiatives, of course, are not limited to local levels of government. A broad range of alcohol policies come under the jurisdictions of the provincial and federal governments. Included are policies governing the marketing and advertising of alcohol, the price of alcohol, the hours and conditions under which it can be sold, and the number of licensed outlets in a community. Each of these policy issues contributes to the overall environment in which alcohol is consumed, and has implications for the relative proportions of Low, Moderate, and High Risk consumers in a community.

Planning efforts at the local level may result in the identification of policy initiatives which, in the opinion of planning committee members, should be considered by provincial or federal authorities. This may result in the initiation of advice to the appropriate individuals. In addition, other steps may be taken to increase the likelihood that these policy measures be seriously considered and adopted.

Notwithstanding the broader policy issues, a comprehensive alcohol and drug plan within a district should include a range of health-oriented policies as part of its recommendations. These policies will enhance the effectiveness of health promotion and, to some extent, health recovery programs and services selected for local implementation.

2.5 Health Recovery Programs and Services

While health promotion services are directed toward populations that have not developed alcohol problems, their health recovery counterparts are employed once problems have developed. The health recovery network includes programs and services consistent with the Early Intervention and Treatment/Rehabilitation strategies (see Figure 3).

Early Intervention

The early intervention strategy recognizes that it is desirable to respond to problems as soon after their onset as possible. There are two stages to the process: the identification of a problem, and the delivery of some form of intervention. For the identification stage, an outside party can be trained to test for the initial signs and symptoms of alcohol problems.* This task can be performed either by health care

* In addition, it is possible that individual drinkers might complete self-assessments through the use of standardized check lists or other instruments. Self assessment and self-help are emerging as effective options in many areas of health care.

providers, such as physicians, nurses, and addictions workers, or by other interested parties such as union stewards, police officers, and social service workers.

The assessment of drinkers can be performed as either a screening function or a case-finding function. Family physicians, for example, might routinely ask their patients a brief set of questions in order to determine whether drinking problems are likely to have begun. This approach is quick and relatively unobtrusive, yet it permits identification well in advance of when problems would normally be detected.

There is no need for the screening or case-finding process to focus exclusively on alcohol consumption. Questions regarding alcohol use can be integrated into a larger set which examines a broader range of lifestyle issues. Through this approach, elevated risk can be detected in any number of areas, and remedial action, such as smoking cessation, weight loss, and stress management programs, can be undertaken as the result of a single assessment.

The second stage of the early intervention process involves the delivery of some form of intervention to those people found to have early stage alcohol problems. Interventions can vary in both intensity and duration ranging from self-help manuals through brief counselling sessions to a more lengthy series of up to eight one-hour sessions. Under some circumstances, the intervention is delivered by the person who completes the initial identification. Under others, a referral can be made to a central clinic or resource where the intervention is delivered by specially trained staff. The goals for early intervention programs are to reduce consumption to either the No Risk or Low Risk categories (depending on the circumstances of the client) and to provide assistance for problems that have occurred as a consequence of alcohol use.

The development of community-based programs and services within the early intervention strategy is still in its infancy. As yet, there are no fully developed models which can be established throughout the province. For this reason, community initiatives are most appropriately planned as demonstration projects and matched with strong evaluation components. As tested program models emerge over time, the early intervention strategy should lend itself more easily to widespread implementation across Ontario.

Treatment/Rehabilitation

Programs and services within the treatment/rehabilitation strategy are directed toward people whose drinking has become destructive. Treatment services are intended to halt these destructive drinking patterns and to stabilize the individual; rehabilitation services address the health and social consequences of such patterns as well as the underlying or contributing factors, in order to reintegrate the person into society as a functioning member. Treatment/rehabilitation goals for people in the High Risk category generally should be oriented toward abstinence as the appropriate outcome.

A comprehensive treatment/rehabilitation system is built around a core set of programs and services. Three key components provide the intake functions of the system: detoxication, assessment, and referral. It is through these components that people enter the system and are properly matched to the services they require. A case management component monitors the client's experience throughout the system, introducing modifications to the treatment plan and addressing other difficulties as required.

For the delivery of treatment and rehabilitation services, a comprehensive system should offer different levels of intensity. In this way, clients can be matched to the least intrusive and most cost-efficient option, while maintaining overall levels of effectiveness. The range of intensity extends from residential programs, the most intrusive

option, through day programs to outpatient programs, which are the least intrusive option.

Following this stage, those clients who require assistance with their reintegration into society can be referred to recovery homes. For clients who successfully complete the treatment/rehabilitation phase, the prevention of relapse is addressed through follow-up programs. Throughout the process, support services can be offered to family members and others whose lives have been affected by the problem drinker. In addition, self-help and mutual support groups can play a vital role in the recovery process either as an enhancement to community treatment/rehabilitation services or as the primary source of assistance.

Successful treatment and rehabilitation is predicated upon a comprehensive assessment of the physical and psychosocial needs of the problem drinker. Accordingly, an extensive range of services may be employed to deal with the direct and contributing causes of the drinking problem. A list of the more common services includes counselling, the improvement of communications skills, vocational training, stress management, nutritional enhancement, recreational therapy and fitness programs. Ideally, these services will collectively serve to re-establish the client's ability to function as an independent and contributing member of society.

The planning of local treatment/rehabilitation systems for alcohol problems involves three principal tasks: establishing a full range of core programs and services; ensuring that these are accessible to local residents; and ensuring that each has sufficient capacity to accommodate local demand. To this end, a forecasting model has been developed by the Ministry of Health and the Addiction Research Foundation for use at the district level throughout Ontario. The model enables planners to estimate the size of the population in the High Risk category within their local jurisdictions and, from this information, to estimate the required capacities for all core components of the local treatment/-rehabilitation system.

When supplemented by local information on referral patterns and accessibility issues, the forecasting model enables planners to make sound decisions about the required number, location and capacities for alcohol treatment and rehabilitation services.

3. Illicit Drugs and Inhalants

Apart from alcohol, various other drugs are used for non-medical purposes by members of the Ontario public. For the purposes of this framework, a selection of these drugs has been grouped under the heading "illicit", which is applied in its generic sense meaning "unlawful" or "forbidden". The most commonly used illicit drugs are:

- cannabis and its derivatives;
- other hallucinogens, including LSD and PCP^{*};
- amphetamines and amphetamine-like compounds;
- cocaine;
- tranquilizers;
- barbiturates; and
- opiate narcotics.

Some of these drugs have legitimate medical uses when taken under the direction of a licensed physician. The medical use of prescription drugs is addressed in Section 4 which follows. As indicated in the opening section, caffeine and tobacco (nicotine) have specifically been excluded from this framework. Finally, the use of inhalants (including glue and other solvents), although not illegal, is paired with the list of illicit drugs in recognition of their role in the development of drug problems in Ontario.

* LSD is the common abbreviation for lysergic acid diethylamide-25 and PCP is the abbreviation for phencyclidine.

Compared to the data on alcohol, statistics for Ontario residents regarding the consumption of illicit drugs and inhalants and the associated problems are limited. In large part, this is because the possession or use of these substances is illegal. For a variety of reasons, inhalant use tends to be concealed by those involved.

Nevertheless, existing survey data suggest that the use of some illicit drugs is fairly widespread, and that a small proportion of the consuming population engages in heavy use. Overall, the use of inhalants is low, but pockets of concentrated use are found in some age and socio-economic groups, as well as in certain geographical locations. Associated problems develop among moderate and heavy users of both illicit drugs and inhalants, and treatment/rehabilitation programs and services are needed in response. At present, however, it is not possible to accurately estimate either the size of the larger user groups or the size of the population requiring assistance.

From a health perspective, there are no known "low risk" levels of consumption for illicit drugs or inhalants. Moreover, illicit drug users seldom know the exact nature or the strength of the drug they are taking, or whether dangerous contaminants are present. These circumstances are compounded further by the fact that simple possession of illicit drugs can lead to arrest, and that a number of other undesirable legal and social consequences usually ensue. For these reasons, any use of illicit drugs or inhalants must be considered as "risk" use.

Within this perspective, the overall goals with respect to the use of illicit drugs and inhalants are:

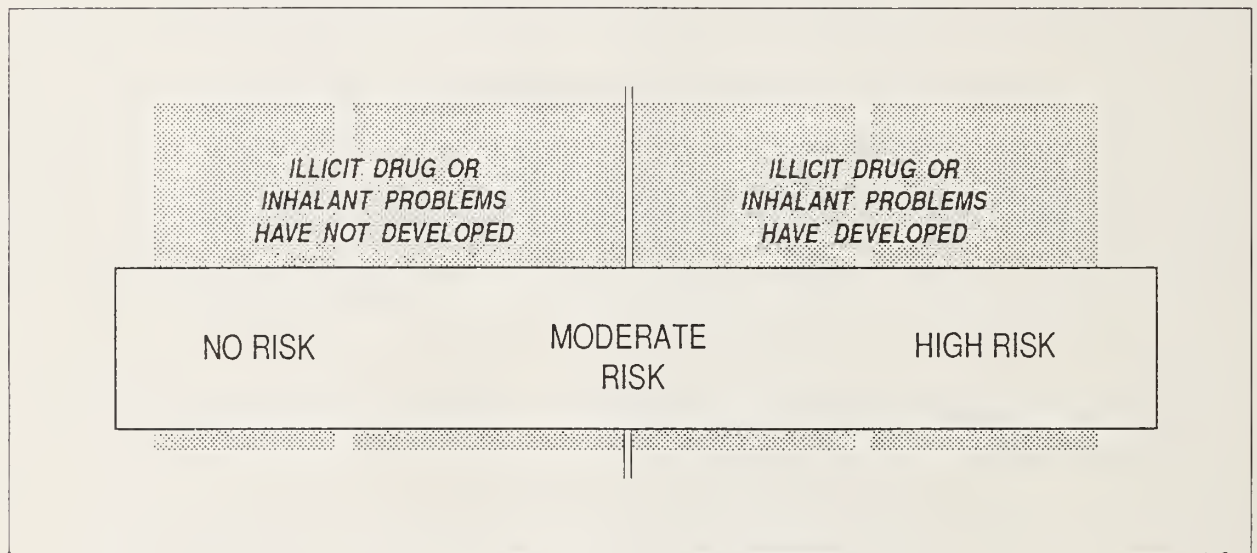
- a) to increase the acceptability and desirability of non-use;
- b) to effect the abandonment of illicit drug and inhalant consumption among users who have yet to experience related problems;
- c) to effect a reduction in illicit drug and inhalant consumption among those who refuse to give up these substances altogether;

- d) to effectively and efficiently address problems that arise from the use of illicit drugs and inhalants; and
- e) to limit the harm experienced by illicit drug users for whom remedial efforts have not succeeded.

3.1 A Continuum of Risk

Since there are no "low risk" levels for the consumption of illicit drugs and inhalants, the risk continuum for these substances is collapsed into three categories: No Risk, Moderate Risk, and High Risk. Figure 4 illustrates this continuum, and aligns the categories with the presence or absence of associated problems.

FIGURE 4
RISK CONTINUUM FOR ILLICIT DRUG AND INHALANT PROBLEMS



The No Risk category includes all people who do not use illicit drugs or inhalants. Although precise figures are not available, survey data suggest that this category contains the overwhelming majority of the Ontario population. For program planning purposes, these people are considered to be free from associated problems as a result of their choice not to use these substances.

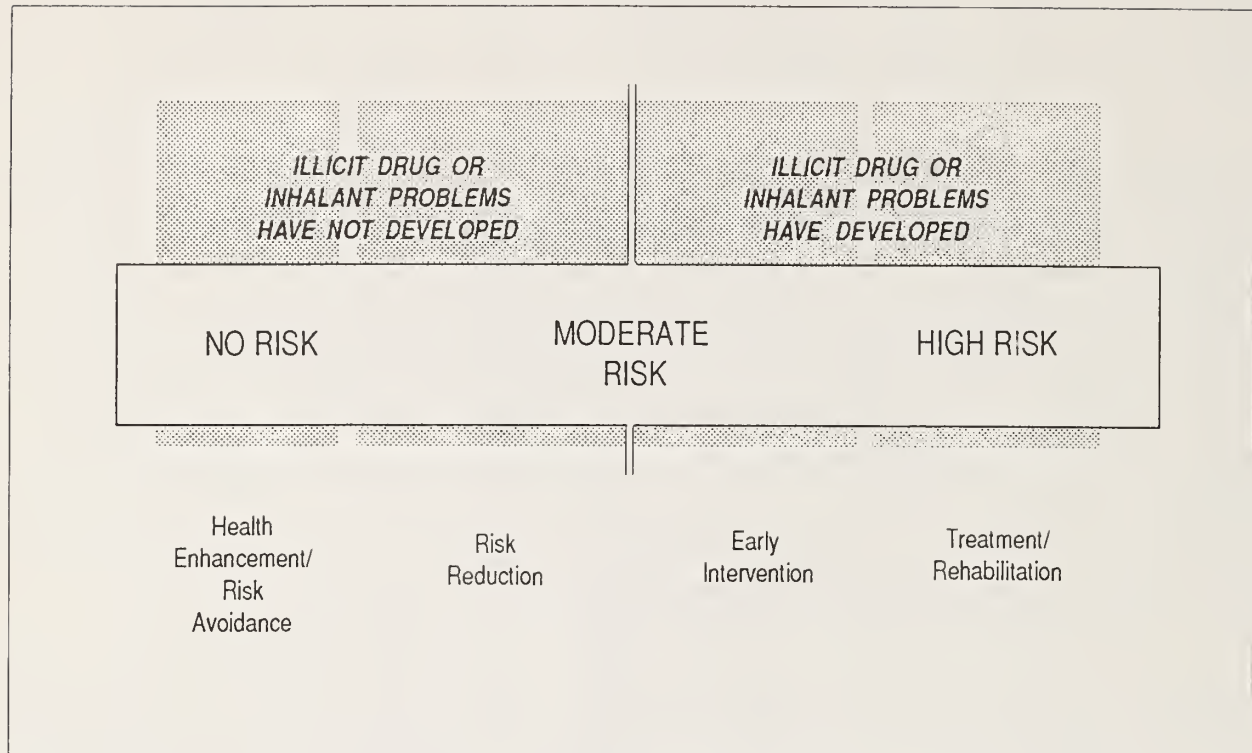
The Moderate Risk category reflects that the likelihood of experiencing health, social, and legal problems increases with any use of illicit drugs or inhalants. It is known, however, that much of the use of these substances is infrequent (including experimental and recreational use) and, in terms of problem rates, can be separated conceptually from heavy use. The Moderate Risk population is split such that one part is aligned with the absence of problems while the other is aligned with the presence of problems. This arrangement suggests that separate program and service strategies are appropriate for each.

Finally, most people in the High Risk category will experience problems as a result of their use of illicit drugs or inhalants. The substances themselves as well as the levels and contexts of use contribute to destructive consumption patterns that harm both users and those around them. The High Risk category contains those people upon whom the treatment/rehabilitation system has traditionally focussed its attention.

3.2 Program and Service Strategies

The populations in each of the three risk categories can be matched to strategies for the planning and implementation of programs and services. These strategies are similar to those described for alcohol consumption, with the exception of the health enhancement and risk avoidance strategies, which are collapsed and aligned with the No Risk category of consumption. Figure 5 illustrates these alignments.

FIGURE 5
PROGRAM AND SERVICE STRATEGIES FOR
ILLICIT DRUGS AND INHALANTS



The following descriptions outline the essential features of each strategy:

Health Enhancement/Risk Avoidance: This combined strategy is directed toward people in the No Risk category, and is intended to increase the acceptability and desirability of not using illicit drugs or inhalants. In so doing, non-use may be introduced and integrated into a range of other healthy lifestyle practices (such as those regarding smoking, fitness and nutrition) in the interests of health and social well-being.

Risk Reduction: This strategy is intended to reduce consumption to the No Risk category before health, social, or legal problems develop among people in the Moderate Risk category who have yet to experience illicit drug or inhalant problems.

Initiatives may be integrated with other risk reduction strategies (such as smoking cessation, weight loss, and nutritional counselling) in the interests of developing greater consistency among lifestyle practices.

Early Intervention: This strategy is intended to identify people in the Moderate Risk category who are experiencing illicit drug or inhalant problems, and to intervene as early as possible in order to effectively manage these problems and reduce consumption to No Risk levels.

Treatment/Rehabilitation: This strategy is intended to provide people in the High Risk category with access to help and comprehensive assessment, and to match the individual to appropriate services. Treatment components are intended to eliminate or reduce illicit drug use, prevent further deterioration, and stabilize the individual; rehabilitation components are intended to restore health and independent functioning to the extent possible.

As with the framework for alcohol problems, two sub-strategies can be incorporated into the five strategies identified above. A Risk Containment sub-strategy can be used to provide insulation to identified "high risk groups." These groups, by virtue of identified correlates, are believed to be at increased risk of using illicit drugs or inhalants, and may warrant special attention within the risk avoidance strategy.

A second sub-strategy, Harm Minimization, can be used for those chronic drug users who are unlikely to respond well to treatment/rehabilitation programs and services. Here, the goal is to limit harm to the user by altering the environment or the conditions of use. For example, street patrols can be initiated in certain neighbourhoods to identify known drug users who need medical help. Alternatively, programs might be introduced to show intravenous drug users how to sterilize syringes in a effort to reduce the risk of their contracting HIV infection and AIDS.

3.3 Health Promotion Programs and Services

Health promotion interventions for illicit drug and inhalant use are those which fall within the health enhancement, risk avoidance, and risk reduction strategies. The overall goals for health promotion are to reduce the incidence of problems associated with illicit drug and inhalant use, and to integrate the non-use of these substances into a variety of healthy lifestyle practices.

As with alcohol, local planning revolves around the selection of an ideal array of programs, services, and policies that will minimize the risk of illicit drug and inhalant problems in the local jurisdiction. Accordingly, the planning process can be aligned with the same steps that were suggested for alcohol:

- a) identify priority target groups within each strategy;
- b) set intermediate and ultimate objectives for each target group;
- c) identify existing programs, services, and policies that best address these objectives given local resources and circumstances;
- d) identify local agencies, institutions, and other resources that can best implement the selected options.

Target groups for illicit drugs and inhalants normally give heavy emphasis to pre-adolescents, adolescents, and young adults. This reflects the fact that most of the use of these substances occurs within these age groups. The focus may be selectively extended to older age groups in relation to a particular drug. For example, the use of cocaine might be identified as a problem that extends to middle-aged people in addition to younger populations.

The product of this planning process is an interlocking array of programs, services, and policies that, in the eyes of the planning committee, represents a sensible and realistic response to illicit drug and inhalant problems in the local jurisdiction. A final step should,

whenever possible and desirable, be the integration of these options with those that address alcohol problems. Preventive curricula in school systems can, for example, extend their focus to alcohol, illicit drugs, and inhalants, attending to each at appropriate times in students' development and in relation to known patterns of use.

Similarly, local policy measures dealing with alcohol consumption can be examined to determine whether they warrant extension to illicit drugs and inhalants. Generally, policies developed by school boards, post-secondary institutions, and employers extend naturally to illicit drug use. With respect to inhalants, the field narrows, with policies adopted by school boards being the only likely option for inclusion.

Clearly, within this planning process it is necessary to decide on the relative degree of emphasis to be placed on alcohol, illicit drugs, and inhalants. In terms of the number of risk consumers and the overall burden of associated consequences, alcohol is by far the largest drug problem faced by Ontarians. Despite this overwhelming fact, there is frequently a tendency to view illicit drug use as the predominant problem and to give it disproportionate emphasis. In each district, planning committees will have to determine the relative level of emphasis that best reflects the patterns of use and associated problems, along with other indicators of the need for health promotion interventions.

3.4 Health Recovery Programs and Services

To date, research evidence suggests that most people experiencing illicit drug and inhalant problems can be served by the same programs and services that address alcohol problems. In fact, many of the people who seek assistance suffer from combined alcohol and illicit drug problems. This is not to suggest that certain adjustments to the delivery of service would not be needed to accommodate both groups of users. Wherever possible, however, community agencies are encouraged to make the necessary adjustments to allow for the concurrent delivery of service to people with alcohol, illicit drug, or inhalant problems.

This report recognizes that a number of treatment agencies in Ontario currently provide services primarily for alcohol problems while others focus on illicit drug problems. Some of these agencies take the position that both populations cannot be served by the same or similar programs and services, and that discrete treatment/rehabilitation systems must be developed for each group. Under unusual and compelling circumstances, argued on a case by case basis, the development of separate programs and services can be supported. Generally, however, the integration of services for alcohol, illicit drug, and inhalant problems is the preferred alternative.

Accordingly, the planning of programs and services for people with illicit drug and inhalant problems should be integrated into the planning exercise for alcohol-related problems. Ideally, the organization and range of treatment and rehabilitation services should be similar for all three populations.

In planning for programs and services, it will be difficult to estimate the nature and extent of local illicit drug and inhalant problems. No forecasting model currently exists to estimate the dimensions of either type of problem, making it necessary to adopt less precise techniques for needs assessment. A local monitoring system, for example, might be designed to measure the incidence of illicit drug or inhalant problems over a six to twelve month period. Alternatively, local survey and waiting list data might be combined to produce a synthetic estimate of demand. A third option might be to initiate a service with limited capacity, and document excess demand through the assessment component. This information can then be used as the basis for subsequent expansion in relation to the surplus demand.

A comprehensive treatment/rehabilitation system should provide effective and efficient services to the majority of district residents experiencing problems as a result of their use of alcohol, illicit drugs, or inhalants. Over time, the planning and evolution of treatment/rehabilitation systems should move Ontario communities toward this goal.

4. Psychotropic Prescription Drugs

In addition to alcohol, illicit drugs, and inhalants, this statement is concerned with problems associated with the use of psychotropic prescription drugs. Here, the related risk behaviour is the inappropriate use of prescription drugs, that is, any use that is not consistent with product monographs and is not prescribed by a physician. This includes the use of prescription drugs left over from an earlier condition or disease, the use of prescription drugs obtained from a physician under fraudulent circumstances, and the use of prescription drugs obtained through means other than a physician's order.

The overall goals with respect to the use of psychotropic prescription drugs are:

- a) to increase the proportion of Ontario residents who use psychotropic prescription drugs only as appropriately prescribed by a physician;
- b) to decrease the proportion of Ontario residents who use psychotropic prescription drugs other than as appropriately prescribed by a physician; and
- c) to effectively and efficiently address problems associated with the inappropriate use of psychotropic prescription drugs.

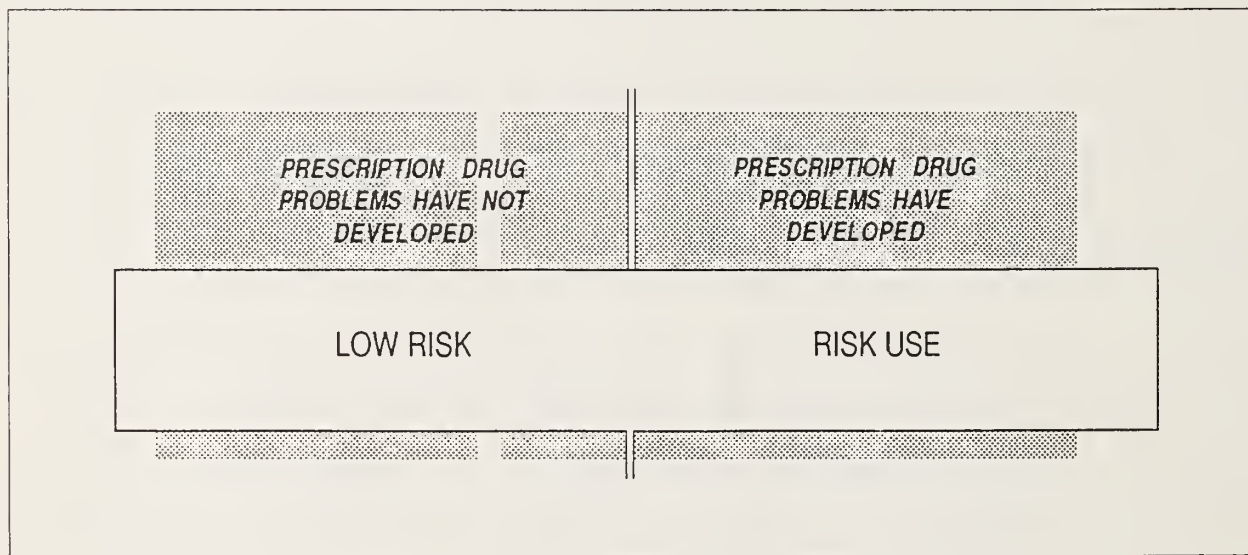
4.1 A Risk Continuum

The use of virtually all psychotropic prescription drugs is associated with some risk of side effects, even when they are taken in compliance with the product monograph. Nevertheless, it is inadvisable to abstain from all prescription drug use, as these medications can be necessary for the well-being, even survival, of the individual. Accordingly, the concept of a No Risk category is inconsistent with psychotropic prescription drug use.

Further consideration suggests that there are two categories of risk associated with the use of psychotropic prescription drugs. Use in compliance with a physician's instructions (and product monographs) can be located within a Low Risk category. All use other than as indicated by a physician (and product monographs) is most appropriately placed in a Risk category. Within this category, the level of risk increases according to a number of criteria, including the type of drug, its strength, the frequency of use, and the contexts under which it is used. The variations among these factors are many, making it conceptually and practically difficult to identify separate categories for Moderate and High Risk use.

Within the single Risk category, some people will develop problems as a result of their use while others will not, despite the elevated levels of risk. The two categories of use are depicted in Figure 6, and aligned with the presence and absence of problems.

FIGURE 6
PROGRAM AND SERVICE STRATEGIES FOR
PSYCHOTROPIC PRESCRIPTION DRUG PROBLEMS

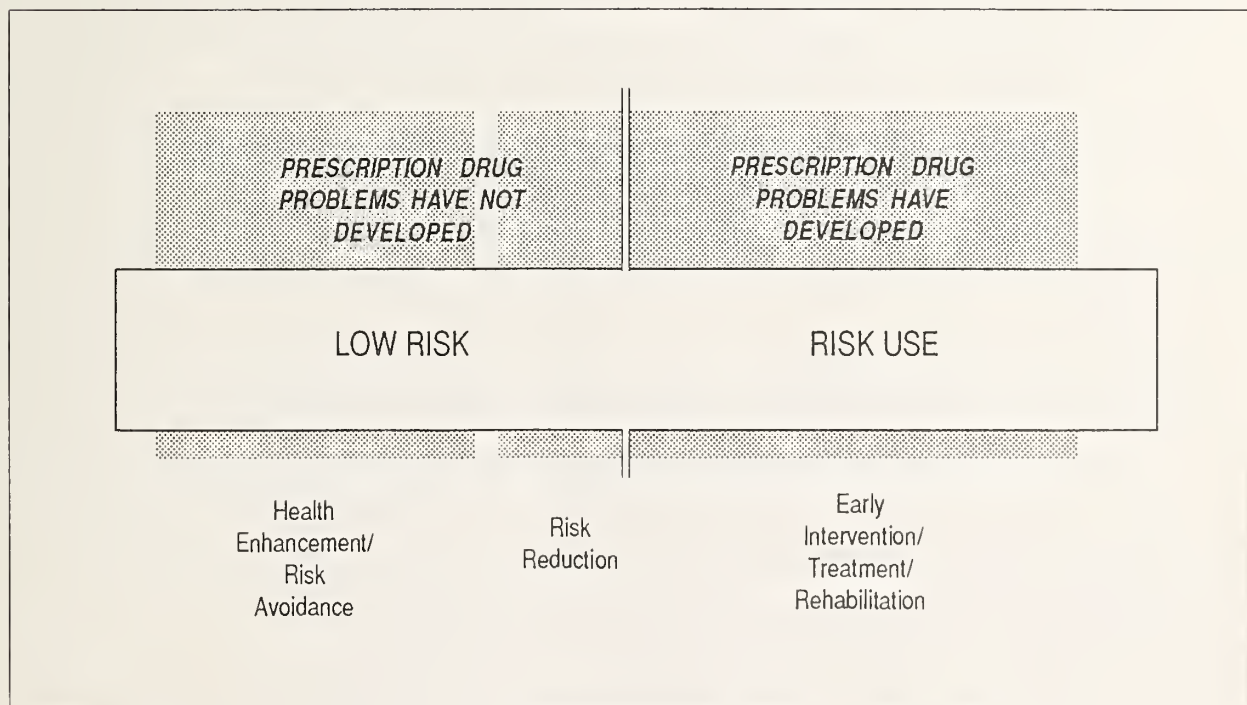


No methodology exists to develop valid estimates of the proportion of Ontario residents who fall into the Risk category, or the numbers experiencing problems as a result of their Low Risk use of prescription drugs. Survey data and assessment records from treatment agencies provide some information on the prevalence of risk consumption and the associated problems, but these statistics underestimate the size of each population. Although the extent of this underestimation is unknown, the numbers are sufficient to suggest that both health promotion and treatment/rehabilitation strategies are warranted.

4.2 Program and Service Strategies

Despite the abbreviated nature of the risk continuum for prescription drug problems, four program and service strategies can be employed. These strategies are aligned with the risk continuum in Figure 7.

FIGURE 7
PROGRAM AND SERVICE STRATEGIES FOR
PSYCHOTROPIC PRESCRIPTION DRUG PROBLEMS



The following descriptions outline the essential features of each strategy:

Health Enhancement/Risk Avoidance: This combined strategy is directed toward people in the Low Risk category, and is intended to increase the acceptability and desirability of using psychotropic prescription drugs only as indicated by a physician. In so doing, it may introduce, integrate, and promote the use of prescription drugs consistent with other healthy lifestyle practices in the overall interests of health and social well-being.

Risk Reduction: This strategy is aimed at those in the Risk category who have yet to experience psychotropic prescription drug problems, and is intended to reduce consumption to the Low Risk category before health, social, or legal problems develop. It may be integrated with risk reduction strategies related to other lifestyle areas in the interests of developing greater consistency among health practices.

Early Intervention: This strategy is intended to identify people in the Risk category who are experiencing psychotropic prescription drug problems, and to intervene as early as possible in order to effectively manage these problems and reduce consumption to Low Risk levels.

Treatment/Rehabilitation: This strategy is intended to provide those in the Risk category who are experiencing serious psychotropic prescription drug problems, with access to help and comprehensive assessment, and to match these individuals to appropriate services. Treatment components are intended to eliminate or reduce Risk drug use, prevent further deterioration, and stabilize the individual; rehabilitation components are intended to restore health and independent functioning to the extent possible.

4.3 Health Promotion Programs and Services:

Health promotion programs and services that focus on psychotropic prescription drug use should be consistent with health enhancement, risk avoidance, and risk reduction strategies. The overall goals regarding psychotropic prescription drugs are to reduce the incidence of associated problems, and to integrate Low Risk use into a variety of healthy lifestyle practices.

The planning steps for psychotropic prescription drugs are similar to those suggested for alcohol, illicit drugs, and inhalants, and include:

- a) the identification of priority target groups within each strategy;
- b) the setting of intermediate and ultimate objectives for each target group;
- c) the identification of existing programs and services that can best address these objectives, given local resources and circumstances;
- d) the identification of local agencies, institutions, and other resources that can best implement the selected options.

A diverse set of target groups can be identified for programs and services dealing with psychotropic prescription drugs. Virtually all age groups can be included, as these drugs are taken by most people when they become ill. Special attention can be paid to broad target groups suspected of having elevated rates for using left-over drugs, obtaining drugs from a physician under fraudulent circumstances, or obtaining psychotropic prescription drugs from illegal distributors.

As with illicit drugs and inhalants, a final step in the process should be the integration, whenever possible and desirable, of psychotropic prescription drug interventions into those selected to deal with alcohol. In all likelihood, this integration will be limited to program and service options as, to date, no examples of local policies dealing with the inappropriate use of prescription drugs have been developed.

Once these programs and services have been fully integrated, each planning district will have identified a comprehensive array of health promotion interventions. Cumulatively, these should stand a reasonable chance of having a favourable impact on alcohol and drug use over time. A monitoring system can be designed to assess indicators of progress from one time period to the next, and conceivably, to compare this progress with pre-determined health objectives for the district.

4.4. Health Recovery Programs and Services:

The inappropriate use of psychotropic prescription drugs is often characterized as a hidden issue. There are few mechanisms to identify people experiencing problems; these people tend not to seek assistance on their own. Moreover, the associated problems are seldom recognized by those who traditionally motivate people with other forms of drug problems to seek help; for example, spouses, family members and employers. Insofar as these observations apply, considerable effort must be expended to sensitize both professional caregivers and the community-at-large to the nature of psychotropic prescription drug problems and the need for intervention.

Psychotropic prescription drug problems may be particularly responsive to early intervention strategies. A number of key people in the community (such as physicians, public health nurses, pharmacists and school guidance counsellors) are well situated to routinely screen and assess people for indications that problems have developed. Moreover, with training, these professionals are optimally positioned to either deliver a brief intervention themselves or to make referrals to a central clinic or resource.

Although the potential for such interventions is high, there are as yet no fully developed community models that could be established throughout the province. For this reason, community initiatives are most appropriately planned as demonstration projects, and matched to strong evaluation components. As tested program models emerge, this early intervention strategy will lend itself to widespread implementation across Ontario.

The organization and delivery of treatment/rehabilitation services for people with serious psychotropic prescription drug problems are similar to services for alcohol problems. In many cases, the same agencies that respond to alcohol problems can accommodate people with prescription drug problems. Moreover, a number of clients will suffer from problems associated with the combined use of alcohol and psychotropic prescription drugs. Certain adjustments to their operations may be necessary, and staff may require specialized training as prerequisites to the development and implementation of services for this group.

As is the case with illicit drugs and inhalants, the planning process as applied to psychotropic prescription drugs is impeded by the absence of related data. It is therefore difficult to estimate the size of the Risk category and the population experiencing problems. This circumstance requires that needs assessments be approached in an indirect manner. The various options identified for illicit drugs in Section 3.4 can also be applied to conducting needs assessments for prescription drug users.

In summary, a comprehensive treatment/rehabilitation system should provide effective and efficient service to district residents experiencing problems as a result of their use of alcohol, illicit drugs, inhalants, and psychotropic prescription drugs. The planning efforts of the District Health Councils, and the funding mechanisms of the Ministry of Health are oriented toward the realization of this goal.

Risk Consumption Behaviours

Alcohol

1. Average levels of consumption: Consuming 14 or fewer standard drinks per week has a low association with alcohol problems. Consuming 15 or more standard drinks per week has a significantly higher association with problems. The level of risk increases with the amount consumed. At the individual level, variables such as lean body weight and gender will influence this risk threshold. For example, all else being equal, women develop complications of alcohol use at lower consumption levels than men.
2. Drinking to intoxication: Consuming four or fewer standard drinks per drinking occasion has a low association with alcohol problems. Consuming five or more standard drinks per occasion has a significantly higher association with problems. Beyond this parameter, weekly consumption should not exceed 14 standard drinks. At the individual level, variables such as lean body weight and gender will influence the level of intoxication.
3. Drinking and driving: Any alcohol in the bloodstream impairs the ability to drive. Consequently, driving with a positive Blood Alcohol Concentration (BAC) is a risk behaviour. The level of risk increases with the BAC, which is calculated as a function of the number of drinks consumed and the rate of intake. At the individual level, variables such as lean weight and gender will influence BACs for any constant intake of alcohol.
4. Daily drinking: Consuming alcohol on three days or fewer per week has a low association with alcohol problems. Daily consumption of alcohol has a significantly higher association with problems.

5. Drinking and Recreational Activities: Any alcohol in the bloodstream impairs the psychomotor coordination required for many recreational activities such as swimming, skiing, and hunting. Drinking in conjunction with these activities increases the risk of accidents. The level of risk increases with the amount consumed.
6. Drinking and Household Activities: Psychomotor coordination is required for many household activities, such as climbing a ladder, using power tools, or using sharp kitchen utensils. Drinking in conjunction with these activities increases the risk of accidents. The level of risk increases with the amount consumed.
7. Drinking During Pregnancy: No level of alcohol consumption is known to be safe during pregnancy. The level of risk increases with the amount consumed.
8. Drinking While on Medication: Alcohol, in conjunction with many prescription and over-the-counter drugs, can result in high levels of impairment. When on medication, alcohol should only be consumed with the agreement of a physician or pharmacist.
9. Drinking and Work Performance: High average levels of consumption and drinking to intoxication can interfere with many activities, including the ability to perform satisfactorily at work. Within certain occupations, however, consuming even small amounts of alcohol either during or immediately prior to work hours can place the individual or others at risk. Consequences may be related to safety, the ability to make sound decisions, or the performance of other functions in accordance with job expectations.

Other Drugs

10. Any Use of Illicit Drugs or inhalants: The composition and strength of illicit drugs, and the presence of harmful contaminants are seldom known. Many illicit drugs and all inhalants are, in themselves, harmful to health and social well-being, even at low doses. All possession and use of illicit drugs is against the law and subject to severe legal consequences. Accordingly, any use of illicit drugs or inhalants is most appropriately defined as risk behaviour.
11. Inappropriate Use of Prescription Drugs: The use of prescription drugs as indicated in the product monograph has a low association with problems. Any use other than as indicated is a risk behaviour. Physicians and pharmacists are charged with the responsibility of conveying appropriate use to the patient. Accordingly, appropriate use can be interpreted as use that is in compliance with the appropriate instructions of a physician or pharmacist. A notable exception occurs when the patient visits more than one physician in order to receive multiple prescriptions for the same complaint.

APPENDIX B

Program and Policy Examples

The alcohol and Drug Framework introduces five strategies by which health promotion and health recovery goals can be addressed. To assist with further understanding of what each strategy might entail, the following chart has been developed. Under each strategy, examples of programs, services, and policies are listed. The lists are intended to be illustrative, not exhaustive, and are not meant to downplay any option by exclusion. In actual delivery, some examples will extend to two strategies, but for the sake of simplicity, are located within the strategy which is best aligned with their objectives.

PROGRAM AND POLICY EXAMPLES

HEALTH PROMOTION INITIATIVES

HEALTH ENHANCEMENT

Fitness and sports programs

Programs to enhance self esteem

Programs to enhance personal competence

Programs to develop problem solving skills

Nutritional awareness programs

Relaxation techniques

RISK AVOIDANCE

Mock Inquests for drinking and driving deaths

"Dr. Cooper" videos on alcohol, tobacco, and marijuana

Parental modeling programs, e.g., Gram of Prevention

School policies to prevent alcohol and drug use among students

Policies to prevent intoxication in municipally-owned facilities

RISK REDUCTION

Programs for the children of problem drinkers

High school programs to reduce drinking and driving

Server Intervention Programs for licensed establishments

"Sober Driver" spotcheck program

"Sober Boater" program

Medication awareness among seniors

HEALTH RECOVERY INITIATIVES

EARLY IDENTIFICATION

Workplace employee assistance programs

Training of health care providers to screen for alcohol problems among clients

Training of physicians to assess patients and provide brief interventions

Community awareness program on the signs of alcohol problems

TREATMENT/ REHABILITATION

Assessment and Referral Services

Detoxification

Alcoholics Anonymous

Outpatient counselling

Day and evening treatment services

Residential or inpatient treatment services

Recovery and reintegration homes

Family support programs

Aftercare and relapse prevention

**A MODEL FOR ESTIMATING REQUIRED
SERVICE CAPACITIES FOR ADDITIONAL
TREATMENT PROGRAMS IN ONTARIO:
AN EXECUTIVE SUMMARY &
RECOMMENDATIONS FOR LOCAL
APPLICATIONS**

1988

Preface

Material presented in this report represents the first step in a process that will provide quantitative estimates of the required service capacities for addiction programs in Ontario. These estimates are based on current knowledge in the addictions field as well as past clinical and research experience within the treatment system in the province. Should either new information become available, or the demographic structure and drinking habits of the population change, future revisions may be necessary or possible.

There are several limitations to the model developed in this paper for estimating required treatment capacities. These may, however, be overcome as the model develops.

First, the model now addresses the need for alcohol treatment services, but does not predict service needs for the treatment of other drug abuse. This may be possible in the future as additional data emerge on the prevalence of drug abuse and the cost-effectiveness of various methods of treatment of drug-related problems.

Second, the model does not predict the need for services for special sub-groups of the population (e.g., youth, women, Native people, elderly). This is due, in part, to the lack of data on the prevalence and severity of alcohol problems in these sub-groups. Future revisions may also incorporate separate quantitative planning models to account for demographic differences among planning areas.

Finally, the model is based on estimates of required service needs and the optimal patterns of service delivery from a provincial perspective. While regional variations in the prevalence of alcohol problems are considered, unique or area-specific problems in service delivery are not (e.g., provision of treatment in areas with low population density, poor road and weather conditions, or special population sub-groups such as Native people). Future

revisions may lead to variations being incorporated into the model to account for some of these regional disparities in treatment system needs.

The above limitations notwithstanding, it is anticipated that this general quantitative model will contribute to policy and systems planning aimed at the development of a full continuum of care for persons with alcohol and drug problems in Ontario.

Introduction and Background

In December of 1985, the Ontario Ministry of Health announced the adoption of its Addictions Services Policy¹ (Ontario Ministry of Health, 1985a). This policy called for the development of alcohol and drug services in the province and has provided direction for the submission of program proposals for new and expanded services. The policy statement advocates the development of a continuum of addiction services in each Ontario community,² and favours cost-effective, non-residential settings for the treatment of alcohol problems. The policy is consistent with the recommendations of the Addiction Research Foundation (ARF) Treatment Task Force Report (Marshman, 1978) and with subsequent program initiatives undertaken by the ARF across the province to develop a community-based network of services (LaRocque, 1980). It also reflects general trends in the mental health sector toward a greater use of community-based resources.

In 1988, the Ministry of Health developed an overall framework for the response to alcohol and drug problems in Ontario (Ontario Ministry of Health, 1988a). This framework built upon the Addictions Services Policy by incorporating health promotion, early identification and treatment under one umbrella for local program and policy development.

The continuum of care advocated by the Addictions Services Policy and The Alcohol and Drug Framework places new emphasis on the early identification of problem drinkers and the need for a broad range of community-based resources, including assessment/referral, case management, detoxification, outpatient counselling, day treatment, and aftercare. The need for community-based residential care is acknowledged, but only for a minority of those individuals who require treatment.

¹ A copy of the addictions Services Policy is presented in Appendix A.

² Community in this context usually refers to the geographic jurisdiction of the District Health Council or equivalent planning body.

Although, in principle, the Addiction Services Policy highlights the need for this full range of services, its utility for program planning and funding decisions is limited by the lack of quantitative guidelines for determining local needs for each component of the treatment continuum. Accordingly, the procedure outlined in this report is envisaged as an extension of the provincial policy to assist in its practical application.

Needs studies in local planning areas have typically identified gaps in service relative to the continuum of care. For example, a needs assessment can examine whether specialized detoxification services exist and whether they are accessible to those who require them. Making comparisons between existing services and the continuum of care has been a useful approach that has been adopted in many Ontario needs studies to date (e.g., Rush, 1985). The approach, however, has its limitations. Determining the need for service usually goes beyond a yes/no consideration of availability and accessibility, to consider "how much" of a particular kind of resource is needed. At present, there are no guidelines for Ontario to determine "how much" of a particular treatment component is required to serve an estimated number of people in need. For example, no procedure exists to estimate the number of people who require detoxification, comprehensive assessment, day treatment, or outpatient counselling. The forecasting model developed in this paper addresses this need for more quantitative data.

Three separate steps are required for the development and implementation of a province-wide model to document the needs for alcohol treatment services.

1. Estimate the number of individuals in each planning area who need each component of the treatment continuum in a given year.
2. Estimate the capacity of the current treatment network in terms of the number of individuals who can be served by each part of the treatment continuum. Determine the unmet need by subtracting, from these figures, the estimates collected in the first step.

3. Convert the unmet needs expressed as individual cases, into operating units for the various kinds of programs along the treatment continuum (e.g., number of assessment workers, outpatient counsellors, day treatment slots, detoxication beds).

This paper focuses primarily on the first of these three steps. The rationale and the methodology used to develop the capacity estimates are described briefly in this Executive Summary. A more detailed description of the methodology appears in a longer report (Ontario Ministry of Health, 1988b). The capacity estimates are herein referred to as quantitative service guidelines.

The development of these quantitative service guidelines was initiated by the Mental Health Planning Branch of the Ontario Ministry of Health in 1986. Work to date has been a collaborative undertaking of the Community Mental Health Branch and the Division of Community Services of the Addiction Research Foundation of Ontario.

Objective of the Quantitative Service Guidelines

The stated objectives of the guidelines are to provide a baseline against which existing service levels may be measured and to identify discrepancies between existing resources and those suggested by the guidelines (Ontario Ministry of Health, 1985b).³

In practice, it is anticipated that the guidelines will be useful for two reasons. First, the guidelines may be used as an adjunct to local needs assessments for treatment services to indicate the level of service required within each part of the continuum of care. They must, therefore, be easily understood, and applicable to a variety of local situations. It is important that these quantitative guidelines do not replace qualitative indicators that have been useful in local needs studies (e.g., key informant opinions on issues of availability and accessibility of existing resources). The best approach to needs studies is a convergent one that tries to integrate data from a variety of perspectives. While quantitative service guidelines are best viewed as a needed source of information concerning the required capacities of alcohol and drug programs, they should not be the only indicators that are used for local need assessments.

In addition to their application in local need studies, the quantitative capacity guidelines may also assist the Ministry of Health (M.O.H.) with its distribution of funds according to need. The guidelines will provide a means by which the needs for a particular service within a given jurisdiction can be assessed relative to: (a) the needs for other types of services in that jurisdiction, and (b) the needs for that same service in another jurisdiction. Thus, the guidelines are intended to facilitate a province-wide systems approach to planning and a fair distribution of funds according to need. As with the application of these guidelines in local need studies, other qualifying factors should continue to be considered in funding decisions.

³ A copy of the Terms of Reference for Service Guidelines for Mental Health and Addiction Services is presented in Appendix A.

Even though the quantitative service guidelines pertain to the treatment of persons with alcohol problems, it is important to recognize that a significant portion of this population also has problems with other drugs (approximately 25%). It is recommended that need assessments for "drug-only" treatment services, and the evaluation of funding proposals for such services, should continue as in the past, pending the possible extension of this methodology to drugs other than alcohol. This is consistent with the practice in most other jurisdictions where general forecasting procedures for addictions services have been developed. Alcohol and other drug-related services are kept somewhat distinct for planning and funding purposes.

In addition to the exclusion of "drug-only" treatment, the model does not include an adjustment to account for ancillary or supportive services required by family members. The procedure only provides an estimate of the number of individuals with alcohol problems (or combined alcohol/drug problems) who require service from different parts of the continuum of care in a given year. When compared to existing service capacities, the unmet need within each component of the continuum will be indicated. Another step will then be necessary to translate the additional required capacity into "program units" such as the required number of beds or treatment service workers. It is during this last stage, when adjustments for the provision of service to family members can be made.

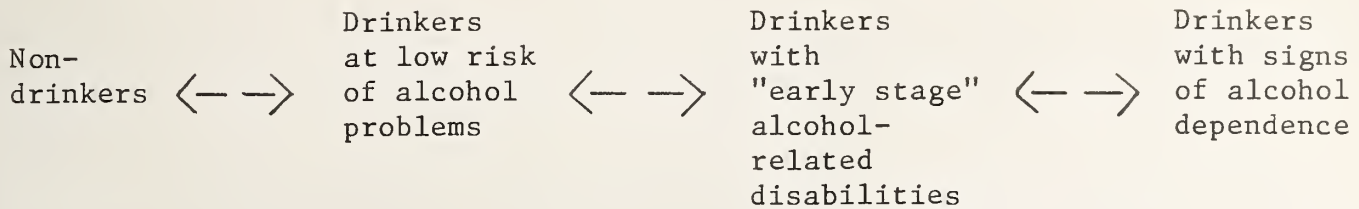
Conceptual Model of Alcohol Problems Underlying
The Addictions Services Policy and the Addictions Framework

The Addictions Services Policy developed in 1985 placed considerable emphasis on the early identification of problem drinkers and on the development of a continuum of local services so that individuals can be matched to the most cost-effective form of treatment. The principles of early intervention and client matching are both based on an underlying conceptual model which theorizes that individuals within the general population experience various levels of severity of alcohol problems. The model postulates that those individuals within each level require a different kind and intensity of intervention.

Four levels of problem severity are usually identified or described in the research literature. People who abstain from alcohol, and who are therefore at no risk of alcohol-related damage unless they choose to drink in the future, are found in the first level. Individuals viewed as being at low risk for alcohol problems due to their current low level and pattern of consumption make up the second level. The third level includes those whose alcohol consumption is more frequent and heavier and who experience alcohol-related disabilities. A common term used to describe individuals at this level is "early stage problem drinkers". The fourth level is characterized by heavy alcohol consumption, alcohol dependence and severe, chronic disabilities. It is individuals in this group who most closely resemble "alcoholics" as traditionally understood by clinicians and the layman (Vaillant, 1983).

Although the model cannot be applied in a rigid, predictive sense at the individual level, it does portray an accurate cross-section of the drinking population, at any given time. Further, it is assumed that individuals at a particular level of severity are at increased risk of progressing to a higher level relative to other drinkers with less serious problems. For example, someone whose drinking has created problems at home, at work, or with the legal authorities is considered to be at a greater risk of developing serious alcohol dependence than someone whose level or pattern of drinking has not yet resulted in any such problems.

Schematically, the model looks like this:



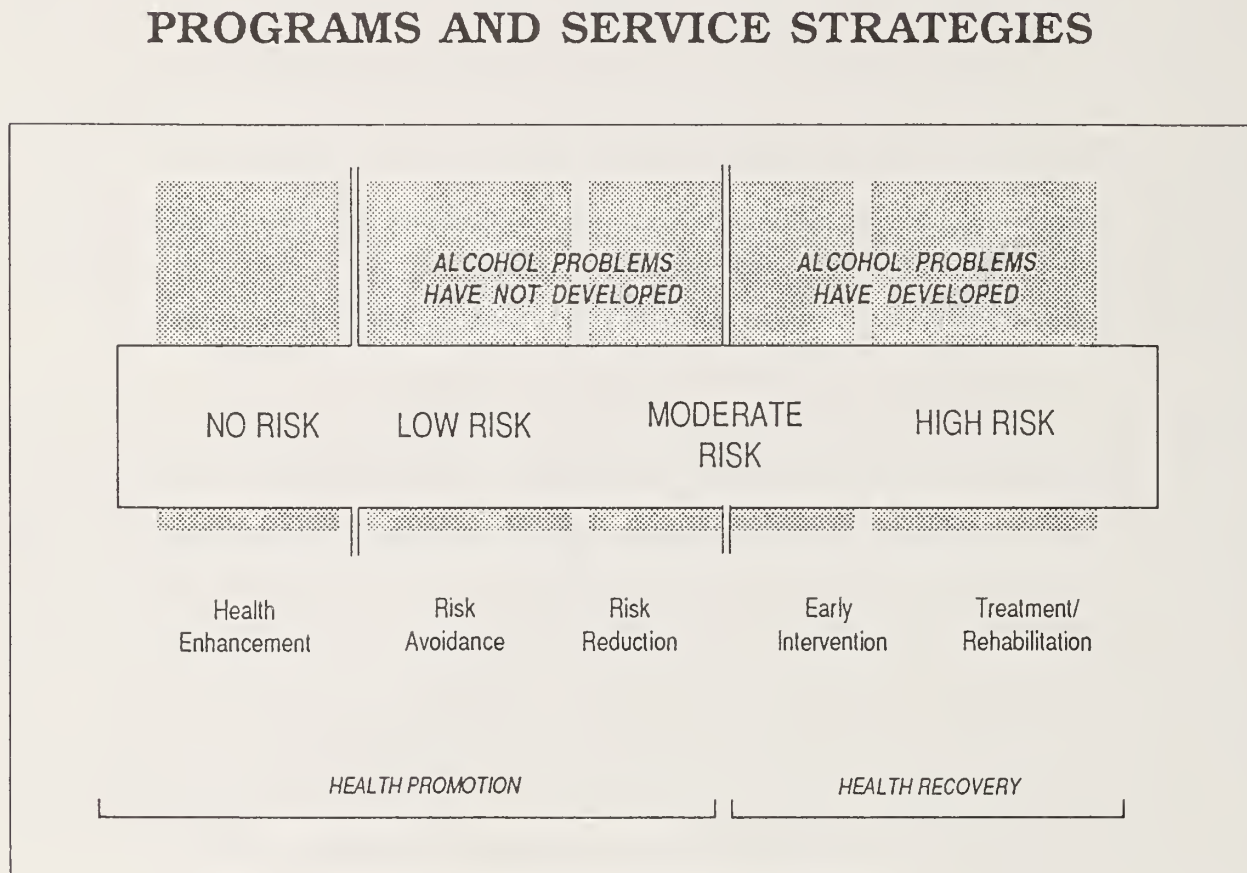
An individual's movement in and out of different levels of severity may be accomplished through "natural" forces such as getting married or divorced, gaining or losing a job, or simply getting older. An individual's movement across levels may also be influenced by the "drinking environment" as it is affected by government policy concerning the use of alcohol (e.g., increasing or decreasing access to alcohol) or by intervention through the community health and social service network. Collectively, government policies and programs represent primary, secondary and tertiary interventions targeted at individuals at various levels of severity, at that particular moment.

Traditionally, government-funded, tertiary treatment resources have been aimed at individuals who are alcohol dependent or "alcoholic". However, the continuum of care advocated by the Addictions Services Policy suggests that an array of treatment resources be extended to a broader population to include individuals who are experiencing less severe alcohol-related disabilities in addition to those who are severely alcohol dependent. This broadly defined target group must be taken into consideration in the method used to estimate the size of the target group for alcohol treatment services and the required capacities of the local continuum of care.

Recently the Ministry of Health's Alcohol and Drug Framework has linked different types of community intervention to various levels of risk along the continuum. Each risk category is associated with an estimated level of weekly alcohol consumption (no risk = 0 drinks; low risk = 1-14 drinks; moderate risk = 15-34 drinks; high risk = 35 or more drinks). Figure 1 shows the program and service strategies advocated for each category. It is important to note that the "HIGH RISK" target group for treatment/-rehabilitation includes not only those individuals who are alcohol dependent, but also a substantial proportion of individuals with less severe alcohol-

related disabilities. The mix of treatment resources in the community (e.g., outpatient versus inpatient) must therefore reflect this mix of prospective clients in terms of problem severity.

FIGURE 1. Program and service strategies in relation to the risk continuum



Source: Ontario Ministry of Health. (1988a)

Review of Existing Methods for Projecting Program Capacities

The following observations and conclusions are drawn from a comprehensive review of addiction planning models in Canada and the United States.

- (1) Ontario lacks a province-wide model for estimating the required capacity of alcohol and drug programs, but this is similar to the situation in most jurisdictions across Canada and the United States. No Canadian province or territory has a general procedure for projecting required capacities. All jurisdictions use a variety of needs assessment methods augmented by input from the local level.
- (2) Of 11 American states that have developed forecasting models, the model is based either on past utilization trends (i.e., demand-based) or on a priori expectations on how the treatment network should optimally perform (i.e., systems-based).
- (3) The "demand-based" methods have limitations, the most serious of which is that any inefficiencies in the current treatment system are perpetuated into the future. This makes for less than optimal planning in Ontario, since the Addictions Services Policy embraces significant principles and types of treatment services that only in recent years have been incorporated into the planning and development of new programs (e.g., assessment/referral services and case management).
- (4) The "systems-based" approach appears to be compatible with the principles and purpose of the Addictions Services Policy and the objectives to which the quantitative estimates are aimed. This method allows the forecasting model to be tailor-made for Ontario, while drawing on the experience of other North American jurisdictions in developing a formula for allocating clients to required treatments.

Developing the Forecasting Model for Ontario

The basic steps to be followed in developing the model are listed below.

- (1) Determine the geographic area and size of the population to be served. This area is referred to as the planning area.
- (2) Estimate the number of problem drinkers and alcohol dependent drinkers within each geographic area. This is the High Risk Group identified in Figure 1, and is referred to as the in-need population.
- (3) Estimate the number of individuals from step (2) that should be treated in a given year. This group is referred to as the demand population.
- (4) Estimate the number of individuals from step (3) that will require service from each component of the treatment system on an annual basis.

STEP 1: DETERMINE THE POPULATION TO BE SERVED BY GEOGRAPHIC AREA AND SIZE

The basic approach is to define planning areas along existing planning jurisdictions and to determine the population of each area from existing census data. An obvious choice is to use District Health Councils (DHC) as the planning areas. However, some parts of the province do not have a DHC, while in others, the DHC is so large that it has been divided for the purpose of planning addiction services (e.g., the District of Cochrane).

The geographic areas selected for use in the forecasting model are the addiction planning areas utilized by the Addiction Research Foundation and local planning committees across the province. The boundaries of most of these planning areas correspond to the boundaries of the local District Health Councils (see Table 1). Two District Health Councils have been split for planning purposes - Metro Toronto and Cochrane (also see Footnote #2 for Table 1). Population data are included in Table 1.

TABLE 1: Counties, population and corresponding DHC for each of the addiction planning areas.

Addiction Planning Area	Counties/ Region	Population ¹ 15 Years	Corresponding DHC
Perth	Perth	51,468	No DHC
Huron	Huron	43,033	No DHC
Thames Valley	Elgin Middlesex Oxford	54,102 262,220 <u>65,340</u> 381,662	Thames Valley DHC
Grey-Bruce	Grey Bruce	58,633 <u>44,519</u> 103,152	Grey-Bruce DHC
Kent	Kent	82,056	Kent DHC
Lambton	Lambton	95,475	Lambton DHC
Essex	Essex	245,149	Essex DHC
Brant	Brant	82,399	Brant DHC
Waterloo	Waterloo	252,587	Waterloo DHC
Haldimand-Norfolk	Haldimand Norfolk	69,907	Haldimand-Norfolk DHC
Hamilton Wentworth	Hamilton Wentworth	337,872	Hamilton- Wentworth DHC
Niagara	Niagara	292,330	Niagara DHC
Wellington Dufferin	Wellington Dufferin	107,742 <u>24,235</u> 131,977	Wellington- Dufferin DHC
Halton	Halton	209,241	Halton DHC
Peel	Peel	439,626	Peel DHC
Simcoe	Simcoe	184,408	Simcoe DHC
Etobicoke York City of Toronto North York Scarborough East York	Metro Toronto	244,563 112,613 525,112 461,375 358,071 88,623	Metro Toronto DHC
York (Region)	York	267,439	No DHC
Durham	Durham	246,950	Durham DHC
Muskoka	Muskoka	32,297	W. Musk-Parry.S. ² DHC E. Musk-Parry S. DHC

¹ The 1986 population figures were used so that they would be comparable to the available data on alcohol consumption and prevalence.

Addiction Planning Area	Counties/ Region	Population 15 Years	Corresponding DHC
Haliburton, Kawartha, Pine Ridge	Haliburton Victoria Northumberland Peterborough	9,737 41,343 53,398 83,204 <u>187,682</u>	Haliburton, Kawartha, Pine Ridge
Hastings Prince Edward	Hastings Prince Edward	85,612 17,921 <u>103,533</u>	Hastings & Prince Edward - No DHC
Frontenac, Lennox and Addington	Frontenac Lennox & Addington	92,373 26,143 <u>118,516</u>	Kingston Frontenac & Lennox & Addington DHC
Lanark, Leeds & Grenville	Lanark Leeds/Grenville	39,461 66,871 <u>106,332</u>	Lanark, Leeds & Grenville DHC
Ottawa-Carleton	Ottawa-Carleton	486,524	Ottawa-Carleton DHC
Seaway Valley	Dundas/Stormont/ Glengarry Prescott-Russell	79,846 44,148 <u>123,994</u>	Seaway Valley DHC
Renfrew	Renfrew	69,188	Renfrew County - No DHC
Parry Sound	Parry Sound	26,846	W.Musk.-Parry S. ² DHC E.Musk.-Parry S. DHC
Timiskaming- Nipissing	Timiskaming Nipissing	30,960 60,651 <u>91,611</u>	No DHC
Sudbury- Manitoulin	Sudbury Manitoulin ⁴	133,864 8,172 <u>142,036</u>	Manitoulin- Sudbury DHC
North Cochrane ³	N. Cochrane	31,088	Cochrane DHC
South Cochrane ³	S. Cochrane	40,304	Cochrane DHC
Algoma	Algoma	99,263	Algoma DHC
Thunder Bay	Thunder Bay	120,304	Thunder Bay DHC
Kenora-Rainy River	Kenora ⁴ Rainy River	42,938 17,272 <u>60,210</u>	Kenora-Rainy River DHC

² These are two recently formed DHCs. Muskoka and Parry Sound are considered two separate planning areas for present purposes.

³ Population data for North and South Cochrane are from the Data Development and Evaluation Branch, MOH, based on Hospital Service Areas in Cochrane District. Data for North Cochrane include the population of three northern communities which are in the far eastern portion of the District of Kenora (Winisk, Attawapiskat and Kashechewan, Population = 1,492 aged 15 and over).

⁴ Population data for Manitoulin and Kenora are based on projections made for 1982-83 since there was a major underreporting of Native reserve populations in these areas in the 1986 Federal Census.

STEP 2: ESTIMATE THE NUMBER OF PROBLEM DRINKERS AND ALCOHOL DEPENDENT DRINKERS WITHIN EACH PLANNING AREA (i.e., the in-need population)

Prevalence estimates based on alcohol sales data and per capita consumption estimates have been prepared and published for each Ontario county (Rush, 1987). These data cover the 12 month period between April, 1985 and March, 1986.

Although this method of estimating prevalence has some limitations⁴, the validity and utility of the approach is sufficient to justify its use in providing estimates of the overall number of individuals in the population who are drinking at various levels of alcohol consumption. This is especially true for small geographic areas where no reasonable alternative exists (Furst & Beckman, 1981). The fact that we are likely to be underestimating rather than overestimating the size of the "in need" population also increases our confidence in using this approach. Resulting prevalence rates must not, however, be viewed as exact figures, but rather as estimates for purposes of program planning.

For each addiction planning area, an estimate is made of the number of people drinking at various levels of risk of alcohol problems, as shown in Figure 1. The risk categories correspond to the average number of standard drinks⁵ consumed per week: NO RISK (0 drinks), LOW RISK (1-14 drinks), MODERATE RISK (15-34 drinks), and HIGH RISK (35 drinks or more).

⁴The influence of tourism on alcohol sales constitutes the largest potential source of error in these prevalence estimates for most planning areas. This may result in an overestimate of treatment needs in a small number of jurisdictions.

⁵A standard drink refers to one 12 oz bottle of beer (5% alcohol), one 1½ oz. shot of spirits (40% alcohol), or one 5 oz. glass of wine (12% alcohol).

Headings used to describe the various risk levels are somewhat arbitrarily selected. However, the categories are generally consistent with research findings which show that as consumption levels increase, so does the risk of problems. In particular, consumption levels of 2-4 drinks and 5-6 drinks per day (or roughly 14-28 or 35-42 drinks per week) are associated with a sharply rising risk for alcohol-related problems, especially damage to health (e.g. Sanchez-Craig & Israel (1985), Hingson et al., (1982), Pequignot et al., (1978)).

Consistent with the new M.O.H. Alcohol and Drug Framework (Ontario Ministry of Health, 1988a) 35 drinks per week from the 1985/86 prevalence estimates is used as the cut-off point for the size of the group in need of specialized tertiary treatment services within each treatment planning area. For the province as a whole, this represents about 7.2% of the population aged 15 years of age and over, or 8.6% of the adult drinking population in Ontario.

It must be noted that the actual percentage of drinkers in each planning area that exceeds this cut-off point will vary depending on the per drinker consumption level in that area. Areas with a high per drinker consumption (e.g., Kenora) will have a substantially higher proportion of the population in need of specialized treatment, than those with a low per drinker consumption. This is an inherent feature of the estimation procedure.

Table 2 shows the resulting number of individuals in need within each of the addiction planning areas.

TABLE 2. Population 15 years of age and over and estimated number of individuals in need of specialized alcohol treatment for each addictions planning area.

PLANNING AREA	POPULATION 15 YEARS AND OVER	NUMBER IN NEED OF SPECIALIZED ALCOHOL TREATMENT ¹
Perth	51,468	3,230
Huron	43,033	2,660
Thames Valley	381,662	24,860
Grey-Bruce	103,152	8,280
Kent	82,056	5,900
Lambton	95,475	7,130
Essex	245,149	17,290
Brant	82,399	5,290
Waterloo	252,587	18,030
Haldimand-Norfolk	69,907	4,600
Hamilton-Wentworth	337,872	23,540
Niagara	292,330	21,600
Wellington-Dufferin	131,977	8,580
Halton	209,241	14,090
Peel Region	439,626	25,880
Simcoe	184,408	17,330
Metro Toronto-Etobicoke	244,563	17,560
-York	112,613	8,090
-City of Toronto	525,112	37,700
-North York	461,375	33,130
-Scarborough	358,071	25,710
-East York	88,623	6,360
York Region	267,439	12,450
Durham	246,950	16,430
Muskoka	32,297	5,340
Haliburton, Kawartha, Pine Ridge	187,682	15,900
Hastings, Prince Edward	103,533	8,510
Frontenac, Lennox & Addington	118,516	9,810
Lanark, Leeds & Grenville	106,332	7,740
Ottawa-Carlton	486,524	32,370
Seaway Valley	123,994	7,250
Renfrew	69,188	6,060
Parry Sound	26,846	2,990
Timiskaming-Nipissing	91,611	7,640
Sudbury-Manitoulin	142,036	13,335
North Cochrane	31,088	2,800
South Cochrane	40,304	3,640
Algoma	99,263	8,780
Thunder Bay	120,304	11,740
Kenora	58,718	7,215
TOTAL	7,145,324	516,840 ²

¹ Rounded to the nearest 10

² This value is the sum of the number in need for all planning areas combined. It varies slightly from an estimate made directly from the total population (N=513,040)

STEP 3: ESTIMATE THE NUMBER OF INDIVIDUALS FROM STEP 2 THAT SHOULD BE TREATED IN A GIVEN YEAR (i.e., the demand population)

In this stage of the procedure an estimate is made of the proportion of the "in-need" population for which treatment should be planned on an annual basis. This population is referred to as the "demand" population. There is general agreement in the literature that the percentage of problem drinkers who are currently seeking, or who have recently sought treatment, is quite low. This holds even for drinkers who view their problem as quite serious. Estimates in the 5 - 15% range are most common when the criteria for alcohol problems are sufficiently broad to include non-dependent problem drinking. A 20% target has been used in some American planning models, but few empirical studies have found that the proportion of individuals seeking treatment is actually this high.

In the forecasting model for Ontario, a range of target values is employed to represent the proportion seeking treatment. The proportion of the in-need population for which treatment services should be planned is therefore not a fixed percentage. Indeed, this proportion is likely to vary across different areas of the province depending, for example, on the nature and extent of outreach and case identification programs, as well as the level of awareness of existing programs. Low, middle and high values of 10%, 15% and 20% are used, with the 20% value being the maximum hypothetical target. Statistical tables generated for each local planning area will contain a low, medium and high estimate for the required capacity of each component of the treatment continuum based on these percentages. Individuals employing these tables in local needs assessments are encouraged to use the mid-point unless they can make a case for an unusually high or low demand population.⁶

⁶ Planning areas where the initial prevalence estimates are thought to be seriously inflated by the effects of tourism (e.g., Muskoka) may elect to compensate for this inflation by selecting the low range for the demand population (i.e., 10%).

STEP 4: ESTIMATE THE NUMBER OF INDIVIDUALS FROM STEP 3 THAT WILL REQUIRE SERVICE FROM EACH COMPONENT OF THE TREATMENT SYSTEM

The service categories for which estimates will be made are listed below with their definition as articulated in the Addictions Services Policy.⁷

- Assessment Referral - Systematic procedures for the identification of client's major strengths and problem areas culminating in a treatment plan and referral(s) for assistance.
- Detoxication - Services provided to clients intoxicated or in withdrawal from alcohol and/or other drugs. These may be provided under medical supervision or in a non-medical detox centre.
- Case-Management - The process of monitoring, tracking, and providing support to a client throughout the course of his/her treatment and after treatment is completed.
- Outpatient Treatment- Treatment provided on a non-residential basis, usually in regularly scheduled sessions (e.g., 1-2 hours per week).
- Day Treatment - Intensive, structured non-residential treatment, typically provided five days per week (e.g., 3-4 hours per day).
- Short-Term Residential Treatment- Treatment provided for an intensive, structured period of time while the client resides in-house. The length of stay is typically less than 30 days.
- Long-Term Residential Treatment- Treatment and/or rehabilitation services provided for a period of time typically longer than 30 days. These programs include recovery homes, halfway houses and three-quarter-way houses.
- Aftercare - Resources or services that provide continuing encouragement and additional services as needed, following a client's completion of a treatment plan.

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The definitions of short-term and long-term residential treatment are not provided in the Policy. The definitions of these services are those recommended by the Addition Research Foundation and used in its province-wide survey of addiction programs (Rush & Ekdahl, 1987).

Figure 2 illustrates how a client's progression through the continuum of care can be conceptualized for planning purposes. Briefly, of the total population of problem drinkers and alcohol-dependent persons in need of treatment, some proportion should be planned for and treated in a given year at specialized addictions services. The remaining, and largest, proportion of those in need will either not seek any therapeutic contact or will have some potential therapeutic contact at general health and social services or self-help groups such as Alcoholics Anonymous. Of those presenting at specialized addictions programs, some will enter detoxification programs directly, while others will go to specialized assessment and/or treatment programs. From each of these entry points, cases filter through various components of the treatment continuum including case management, assessment, treatment settings (outpatient, day, short and long term residential) and aftercare. Two points of drop-out are included in the model, the first being after assessment and before treatment; the second during treatment but before aftercare.

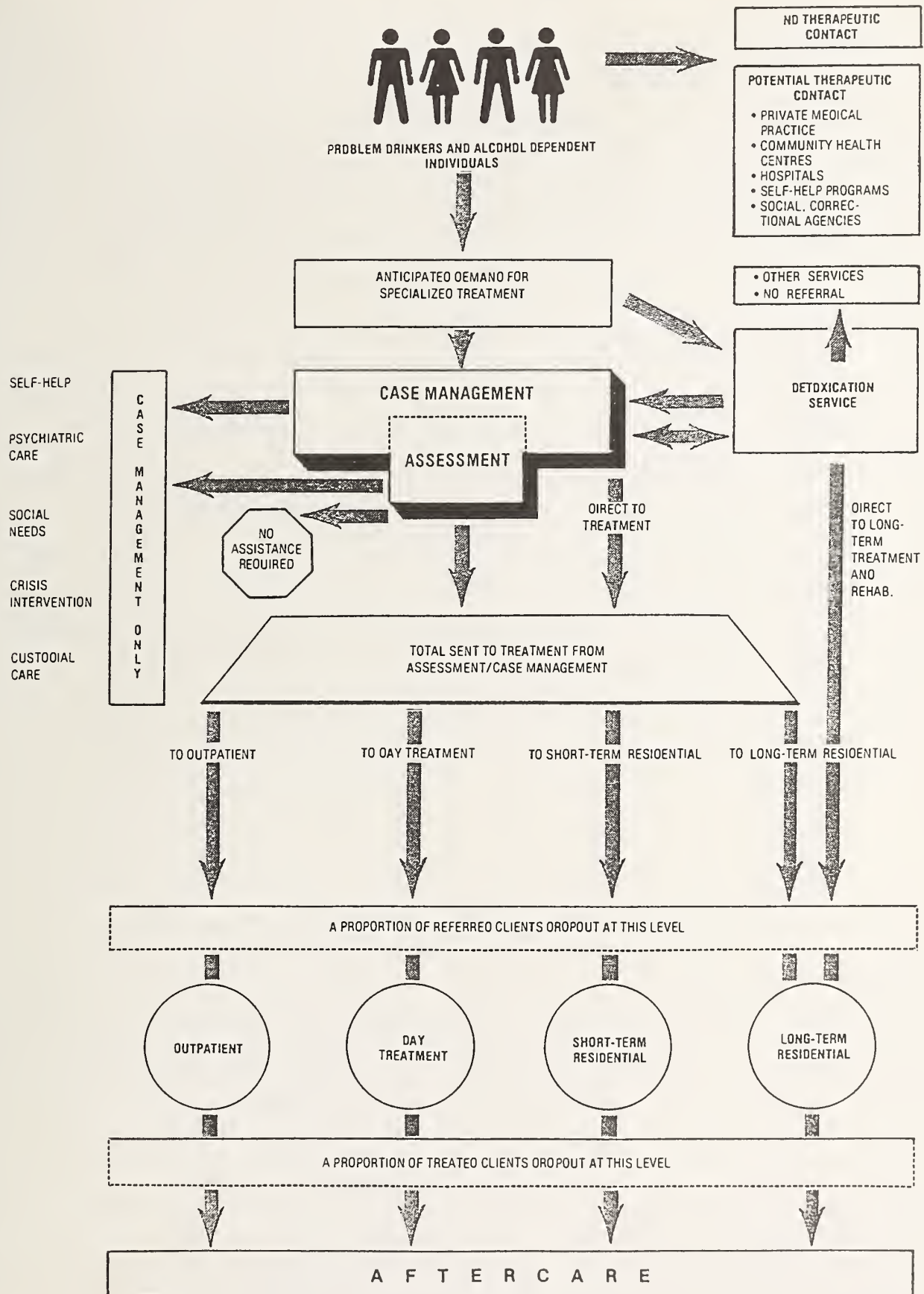
The following sources of information were used to estimate the proportions for assigning individuals to each treatment category within the model:

- a client monitoring system operated by the Addiction Research Foundation for assessment and referral services in Ontario;
- the detoxification reporting system of the Ministry of Health;
- the triennial provincial survey of alcohol and drug programs in Ontario conducted by the Addiction Research Foundation;
- published research literature on patient characteristics, the cost-effectiveness of treatment, and rates of completion from treatment;
- informed opinion from clinical and research experts in the addictions field; and
- the system-based forecasting models used in American jurisdiction⁸.

8

The American-based models provide little empirical base for their estimates. Although these models are based primarily on clinical and research opinion within their jurisdiction, they do provide information relevant to some of the estimates needed in the Ontario model - information which is not available from any other source.

FIGURE 2. Schematic diagram of client's progression through a comprehensive continuum of care.



These sources of data will help establish the levels of service that should be provided in the ideal treatment system. Where possible, empirical research has been used to yield the best possible estimate of a given parameter in the model. If empirical research did not exist, or was judged to be of too low a quality to assist in setting the estimate, the current levels and patterns of service delivery were used and adjusted where necessary. Adjustments were based on needs assessment data from various studies in Ontario or the United States, or on qualitative judgements of need from individuals knowledgeable in that particular aspect of alcohol treatment system.

Finally, with respect to the development of these estimates it should be noted that for each parameter of the model there is really a hypothetical range of values and the estimate selected is the best estimate available for the mid-point of this range, for the province as a whole. For example, the model estimates that 55% of the cases requiring specialized treatment following assessment should be treated on an outpatient basis. Although this is selected as the best estimate available for the province, it could be argued that a slightly lower figure may be more reasonable for those parts of the province with low population density and where travel to treatment is made difficult by road and weather conditions. In such areas there may be a corresponding increase in the need for residential treatment.

An Example to Illustrate the Estimates in the Model

In Figure 3, the forecasting model is applied to a hypothetical population of 10,000 problem drinkers and alcohol-dependent persons in need of specialized tertiary treatment. The bracketed numbers in this figure show the final estimates that have been made for each part of the model.⁹

⁹ The full report on this procedure (Ontario Ministry of Health, 1988b) provides the rationale for each of these estimates.

FIGURE 3 Projected treatment capacities for in-need population of 10,000 individuals.

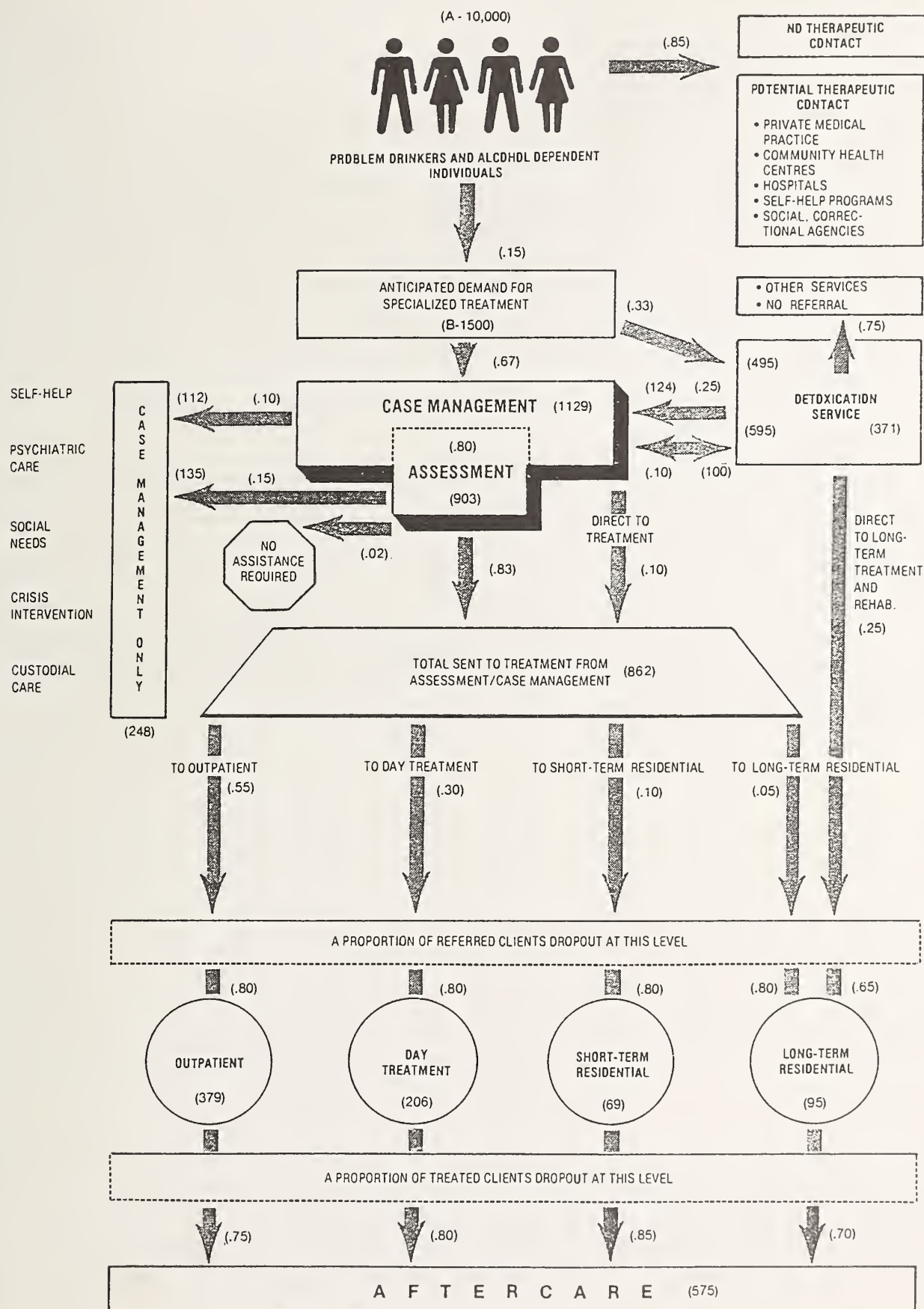


TABLE 3 Capacity guidelines for hypothetical population of 10,000 in need of specialized, tertiary treatment.

ADDICTION PLANNING AREA: Hypothetical Area

IN-NEED POPULATION: 10,000 DEMAND POPULATION¹: HIGH 2000 MED 1500 LOW 1000

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(794)	(1204)	(506)	(276)	(92)	(126)	(767)	(1505)
	MED	595	903	379	206	69	95	575	1129
	(LOW)	(397)	(602)	(254)	(138)	(46)	(63)	(383)	(752)
ESTIMATED ² SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

² TO BE FILLED IN WITH ACTUAL CAPACITIES FROM THE TREATMENT SYSTEM BEING EXAMINED

Table 3 is intended to facilitate interpretation of the results shown in Figure 3. The estimates of the required capacities of each part of the continuum of care are summarized in the first row. Note that in Table 3, three numbers are provided for each part of treatment continuum. These three numbers reflect the three estimates for the size of the "demand population", that is 20%, 15%, and 10% of the "in-need" population. The second row is reserved for an estimate of the current supply of available services. The third row would show the "net need", which is the difference between the capacity estimates (Row 1) and current supply (Row 2). Since this is obtained by subtracting Row 2 from Row 1, high, medium and low estimates of unmet need can be obtained. The results show, on a quantitative basis, those parts of the treatment continuum with the largest relative need, expressed in terms of the number of individuals requiring treatment.

When the results of the model are converted to tabular form in this fashion, the procedure meets its objective of indicating relative need within and across jurisdictions in a manner which is readily applied and understood.

Application of the Model

The model is designed for application at both the provincial and local levels.

At the provincial level, the model can be used to assess the relative need for different services from one planning area to the next. This function requires an annual update of current treatment capacities across the province, a task best accomplished through ongoing information systems and treatment surveys.¹⁰ Comparative statistical tables prepared for the province as a whole will provide a broad framework to help set priorities for new addiction services in all jurisdictions.

¹⁰ Every three years, the Addiction Research Foundation conducts a survey of all alcohol and drug programs in the province. Although the survey data are limited in many respects as estimates of program capacity, they are nonetheless an important source of information for a provincial overview.

With respect to local applications, the model can be used to assess the relative need for different services within a single planning area. An earlier version of the model has been field tested locally by the Wellington-Dufferin District Health Council. Those wishing to use the model in a local need assessment should consult the Council's¹¹ report on the project for a demonstration of its procedures and principles.

The general steps that are recommended for using the model in a local needs assessment are as follows.

1. Organize a planning committee with as close a link as possible to the District Health Council (or equivalent planning body if no DHC exists).
2. Ensure that the human and financial resources are available for data collection and preparation of a final report.
3. Consider the need to expand the needs assessment to include both treatment and health promotion. If the expanded focus is adopted, decide how health promotion will be incorporated into the study.¹²
4. From Appendix B of this report, review the appropriate table for the planning area under study, showing the estimated required capacity of the treatment network (high, medium and low estimate). Consider and document unique features of the area which may not be taken into account in the model (e.g., unique population characteristics, population density, distance, or other difficulties accessing treatment).
5. Decide whether to estimate the additional capacity that is required for drug-only cases.¹³ If so, incorporate these data into the top row of the table. (If not, be sure that current capacity (Step 6) also excludes drug-only treatment).

¹¹ The full report is available from the Wellington-Dufferin District Health Council, 317 Speedvale Ave. E. Guelph, Ontario N1E 1N3.

¹² An approach to this task is incorporated in the Wellington-Dufferin study.

¹³ In the Wellington-Dufferin application of the model, a rough approximation for drug-only cases was incorporated. This step is optional.

6. Collect data on the current capacities of the local addictions network by personal interview or other data collection methods. A series of tables showing the current capacity of treatment programs in all planning areas has been prepared (Ontario Ministry of Health 1988c). Since treatment networks can change in a short period of time, these tables should serve only as a starting point for the needs assessment and must be reviewed for accuracy. If new data are added to the table, it is important that capacity be defined as the number of individuals with alcohol problems that can be treated on an annual basis.
7. Consider the estimated required capacity and current capacity and, by subtraction, obtain the unmet need for each component of the continuum of care.
8. Rank order the treatment components based on the relative size of the unmet need.
9. Collect other quantitative and qualitative data concerning treatment needs (e.g., indicators of the needs of special target groups, key informant opinion, waiting lists at existing programs).
10. Review all the quantitative and qualitative indicators of need and have the planning committee give a final priority score for the development or improvement of each component of the treatment continuum.
11. Use these final priorities as a guide for submission and assessment of local funding proposals.

Table 4.2 from the Wellington-Dufferin needs assessment report shows the final statistical table obtained in that study. In terms of the number of individuals needing care, the relative need was highest for case management, assessment, aftercare, detoxification and out-patient counselling.

TABLE 4.2 Comparison of the Estimated Capacity Guidelines for Alcohol Treatment Services Calculated Using the Forecasting Model, with Estimates of the Service Capacity Currently Available in Wellington-Dufferin^{*}

	DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE (# CASES)	418	826	347	190	63	73	519	1,032
ESTIMATED SUPPLY LOCALLY ANNUAL (# CASES)	0	343	0	96	120	0	APPROX. 80	APPROX. 440
NET NEED	418	483	347	94	0	73	437	APPROX. 600

^{*} This table has been reprinted with the permission of the Wellington-Dufferin DHC.

The following excerpt from the DHC report shows how these data were used to help identify local priorities for service development.

"The Ranking of Options for Treatment/Rehabilitation Services Development. Members of the Treatment Services Steering Committee were asked to assign a score, on a scale of 1 - 10, to each of the 8 Service Development Options identified in Section 4.4 (see next page). The score reflected the Committee members' perception of the importance of the particular option to improving the treatment system in the district.

Committee members were asked to consider qualitative information (such as the issues raised by key informants and service providers) and quantitative information (such as the capacity estimates developed using Rush's model and statistics on the operation of individual programs). The average score received by option, and the rank order of the scores, are shown in Table 4.7.

The average scores received by the options tended to be high and very close. Thus, between the options ranked first and seventh there was a difference in the score of only 2.8 points. This reflects the Committee's perception that strong arguments could be made for the prompt development of many of the services.

The options ranked 1-3, dealing with the need for out-patient programming (in general, and for those with drug problems), and for detoxification services, are consistent with the issues and needs most frequently identified by key informants (Table 4.1).

The Steering Committee's ranking did not give as high a priority to the expansion of resources for assessment and case-management as the estimate of service capacity deficits (based on Rush's model, Table 4.2) would have suggested. In part, this is a result of the Committee's perception that the development of out-patient programming (the Options ranked 1 & 2) will create additional capacity for assessment and case management within the Assessment and Information Centre. Staff at the Centre will no longer have to devote so much time to follow-up counselling."

(Wellington-Dufferin DHC, 1987, p.105-107).

As demonstrated in this application of the model, the procedure provided a quantitative estimate of the unmet need for addiction services along the continuum of care. These estimates then became a key indicator of those services which should be given the highest priority for development. Other qualitative indicators of need were also considered. The resulting priorities for service development reflected both the quantitative service guidelines as well as the opinion of local key informants.

TABLE 4.7

Options to Improve the Addictions Treatment System
in Wellington-Dufferin

#	Option	Average Score	Rank
1.	Establish the capability in Wellington-Dufferin to provide detoxification services to men and women whose primary problems are associated with their use of alcohol or other drugs.	8.2	3
2.	Expand the capability in Dufferin, Guelph & rural Wellington county, to provide assessment/referral & case management services.	6.8	6
3.	Establish the capability in Dufferin, Guelph & rural Wellington County to provide outpatient counselling services for people whose problems are primarily associated with their use of alcohol, & who may or may not have secondary problems associated with their use of other drugs.	9.0	1
4.	Establish the capability in Wellington-Dufferin to provide outpatient counselling & day treatment services for people whose problems are primarily associated with their use of drugs other than alcohol, & who may or may not have secondary problems associated with their use of alcohol.	8.8	2
5.	Expand the capability in Wellington County to provide day treatment services to people whose primary problems are associated with their use of alcohol, & who may or may not have secondary problems associated with their use of other drugs.	4.9	8
6.	Establish the capability in Dufferin County to provide day treatment services to people whose primary problems are associated with their use of alcohol, & who may or may not have secondary problems associated with their use of other drugs.	6.2	7
7.	Establish the capability in Wellington-Dufferin to provide long term residential care (half-way house) to people who have completed treatment or detoxification, or are undergoing treatment, for alcohol or other drug problems, & who require support & employment counselling as part of their process of social re-integration.	7.5	5
8.	Establish the capability in Wellington-Dufferin to provide non-residential aftercare to people who have completed treatment for alcohol or other drug problems.	7.6	4

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APPENDIX A

Ministry of Health
Addictions Services Policy

and

Terms of Reference for Service Guidelines
for Mental Health and Addictions Services

ADDICTIONS SERVICES POLICY

PURPOSE:

To provide detailed information on the Addictions Services Policy.

SUMMARY OF POLICY

Policy

Policy will achieve the following objectives:

- o provide a clear direction for the development of effective and accessible addictions services for the early identification and treatment of alcohol and drug problems in Ontario.
- o establish a framework within which service planners can proceed to:
 - make more appropriate use of existing resources
 - identify service gaps
 - develop appropriate programs and services
 - identify special program needs of specific client populations such as francophones, women, the aged, natives and other minority groups
 - develop local coordinating mechanisms for treatment services

The Ministry policy will provide direction for submissions on new or expanded addictions services to ensure a community orientation with emphasis on the development of a continuum of care:

- o to realize a balance between community and institutional-based programs;
- o to ensure access according to need; and
- o to reflect the mounting research evidence in favour of community-based addictions programs which emphasizes day and out-patient treatment.

Addiction Policy/Direction Details

A) Continuum of Care

- ° The Ministry of Health policy reflects current research evidence on addiction treatment by supporting the development of a continuum of addictions services in each community that will provide:
 - an information dissemination strategy for health and social service personnel that will ensure earlier identification of problem drinkers and users of hazardous substances
 - access to assessment/referral, case management services and to detoxication for clients suffering from the acute-effects of alcohol and other drugs
 - access to cost effective treatment which emphasizes day and out-patient treatment
 - aftercare, and evaluative follow-up to monitor client outcomes
 - Services Co-ordination
- ° Within the framework of a continuum of care, local planners can begin to ensure that:
 - early identification of problem drinking and substance abuse is a high priority
 - there is local capability for the assessment of the clients' physical, mental and social problems
 - the client is given advice and assistance to interrupt his/her harmful behaviour while avoiding the use of expensive interventions
 - there is the most economic use of resources by treating only identified problems and only in the agencies best qualified for the particular purpose
 - services are available to meet the special needs of specific client groups such as the aged, women, francophones, natives, and other minority groups
- ° D.H.C.'s are encouraged to review existing addiction services and plan for enhanced services within this framework, including the development of appropriate program proposals.
- ° The Ministry encourages agencies submitting proposals for funding of addictions services to include adequate follow-up mechanisms in the proposed program plan. There is a need: to ensure that clients receive continuing support and, where necessary, additional services; and to monitor outcomes.

- o The Ministry encourages co-ordination among the various system components and at various levels i.e. clients, agencies and funders. Services co-ordination is vital in the large and varied network which deals with the multiple physical/mental and/or social problems experienced by the addictions services clientele. In addition to Health, other ministries, (notably M.C.S.S.) and numerous volunteer, self help and religious groups, fund or provide services which will continue as a vital part of the service system.

B) Research Evidence

- o The mounting research evidence in favour of community-based addictions programs that emphasize day and out-patient treatment is now reflected in the Ministry policy. These programs are more economical and as effective in treating the majority of clients as their counterparts in the institutional settings.
- o The Ministry will continue to support and encourage community-based assessment/referral, case management, and out-patient services, and day treatment through the Community Mental Health Services Program. These programs' growth will be dependent on DHC ranking of local proposals, evidence of need for specific populations and/or geographic distribution, and availability of Ministry funding.

C) C.M.H.S.P.¹ Funding for Community-Based Addictions Programs with a Residential Component

- o Under this policy direction, the Ministry emphasizes the role of standardized client assessment as well as day treatment and out-patient services as vital components in the provision of a continuum of care for the majority of clients in a community.
- o The Ministry also recognizes the need for a residential treatment component within a continuum of addictions services for the relatively small percentage of clients assessed as requiring such care.
- o Unlike non-residential addictions programs, which are funded 100%, community-based residential programs receive only program funding and often charge clients fees for accommodation and food.
- o 100% funding will now be provided to existing Ministry of Health community-based residential programs. Removing the need for client charges will make these community programs as financially accessible as institutional programs which are OHIP insured.
- o Similarly, 100% C.M.H.S.P. funding will be available for any new residential programs that have a demonstrated need and have been approved for funding by the Ministry through the normal District Health Council process.

¹ Community Mental Health Services Program, Ministry of Health

TERMS OF REFERENCE

SERVICE GUIDELINES FOR MENTAL HEALTH

AND ADDICTIONS SERVICES

PURPOSE

- ° To establish population-based guidelines for service levels as bases for planning, focused on community-based services within both the continuum of mental health services and the continuum of addictions services.

BACKGROUND

- ° The Ministry of Health supports the development of a continuum of mental health services and a continuum of addictions services in each community, via:
 - a continuum of mental health services as defined by the Mental Health Services Framework
 - A continuum of addictions services as outlined by the Addiction Research Foundation
- ° Ministry of Health guidelines exist in relation to institutional bed numbers but these were developed some years ago, predating the shift in focus to community-based services, and may not reflect current needs and practices.
- ° Service guidelines for community-based services have not been developed to date.

ACTION PLAN

In order to develop population-based service guidelines for mental health services and addictions services, the following activities will be undertaken.

1. Examine existing Ministry of Health Service guidelines for mental health and addictions services in order to identify their limitations and potential utility.
2. Conduct a comprehensive review of the literature related to the allocation of health/social services.
3. Analyze relevant literature findings and identify those which address limitations of existing Ministry guidelines and are likely to be applicable to the Ontario scene.
4. Based on the results of the above activities develop proposed guidelines, quantifying the services (included in the addictions continuum and the mental health continuum reference above) which are required by a given population base.

5. The proposed guidelines will be used as baselines to measure existing service levels and identify discrepancies between existing resources and those suggested by the guidelines.

Application of the guidelines will take into account qualifying factors such as geographic location and population distribution.

November 26, 1985

APPENDIX B

Quantitative Service Guidelines For Each Addictions Planning Area

The following tables show the required service capacity for each part of the continuum of care. The first 40 tables are for the addiction planning areas followed by one table for the province as a whole. Each table contains a high, medium, and low estimate corresponding to the range for the estimated proportion of the "in need" population that should be treated in a given year (20%, 15%, or 10%).

Other reports (Ontario Ministry of Health, 1988c) focus on estimating the current supply of treatment services in each of the planning areas and, by subtraction, obtaining a high, medium, and low estimate for the net need.

ADDICTION PLANNING AREA: Perth

IN-NEED POPULATION: 3230 DEMAND POPULATION¹: HIGH 646 MED 484 LOW 323

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(256)	(388)	(163)	(89)	(30)	(41)	(284)	(486)
	MED	192	292	123	67	22	31	185	365
	(LOW)	(128)	(194)	(82)	(46)	(15)	(20)	(123)	(243)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Huron

IN-NEED POPULATION: 2660 DEMAND POPULATION¹: HIGH 532 MED 399 LOW 266

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(211)	(320)	(135)	(73)	(24)	(34)	(204)	(400)
	MED	158	240	101	55	18	25	153	300
	(LOW)	(106)	(160)	(67)	(37)	(12)	(17)	(102)	(200)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Thames Valley

IN-NEED POPULATION: 24860 DEMAND POPULATION¹: HIGH 4972 MED 3729 LOW 2486

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1974)	(2993)	(1258)	(686)	(229)	(314)	(1906)	(3741)
	MED	1480	2245	943	514	171	236	1430	2806
	(LOW)	(987)	(1497)	(629)	(343)	(114)	(157)	(953)	(1871)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Grey-Bruce

IN-NEED POPULATION: 8280 DEMAND POPULATION¹: HIGH 1656 MED 1242 LOW 828

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(657)	(997)	(419)	(228)	(76)	(105)	(635)	(1246)
	MED	493	748	314	171	57	78	476	935
	(LOW)	(329)	(498)	(209)	(114)	(38)	(52)	(317)	(623)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Kent

IN-NEED POPULATION: 5900 DEMAND POPULATION¹: HIGH 1180 MED 885 LOW 590

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(468)	(710)	(298)	(163)	(54)	(75)	(452)	(888)
	MED	351	533	224	122	41	56	339	666
	(LOW)	(234)	(355)	(149)	(81)	(27)	(37)	(226)	(444)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Lambton

IN-NEED POPULATION: 7130 DEMAND POPULATION¹: HIGH 1426 MED 1069 LOW 713

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(566)	(858)	(361)	(197)	(66)	(90)	(547)	(1073)
	MED	425	644	270	148	49	68	410	805
	(LOW)	(283)	(429)	(180)	(98)	(33)	(45)	(273)	(536)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Essex

IN-NEED POPULATION: 17290 DEMAND POPULATION¹: HIGH 3458 MED 2593 LOW 1729

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1373)	(2082)	(875)	(477)	(159)	(219)	(1326)	(2602)
	MED	1030	1561	656	358	119	164	994	1952
	(LOW)	(686)	(1041)	(437)	(239)	(79)	(109)	(663)	(1301)
ESTIMATED SUPPLY									
NET NEED									
	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Brant

IN-NEED POPULATION: 5290 DEMAND POPULATION¹: HIGH 1058 MED 793 LOW 529

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(420)	(637)	(268)	(146)	(49)	(67)	(406)	(796)
	MED	315	478	201	109	36	50	304	597
	(LOW)	(210)	(318)	(134)	(73)	(24)	(33)	(203)	(398)
ESTIMATED SUPPLY									
NET NEED									
	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Waterloo

IN-NEED POPULATION: 18030 DEMAND POPULATION¹: HIGH 3606 MED 2704 LOW 1803

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1432)	(2171)	(912)	(498)	(166)	(227)	(1382)	(2713)
	MED	1074	1628	684	373	124	171	1037	2035
	(LOW)	(716)	(1085)	(456)	(249)	(83)	(114)	(691)	(1357)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Haldimand-Norfolk

IN-NEED POPULATION: 4600 DEMAND POPULATION¹: HIGH 920 MED 690 LOW 460

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(365)	(554)	(233)	(127)	(42)	(58)	(353)	(692)
	MED	274	415	174	95	32	44	265	519
	(LOW)	(183)	(277)	(116)	(63)	(21)	(29)	(176)	(346)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Hamilton-Wentworth

IN-NEED POPULATION: 23540 DEMAND POPULATION¹: HIGH 4708 MED 3531 LOW 2354

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1869)	(2834)	(1191)	(650)	(217)	(298)	(1805)	(3543)
	MED	1402	2126	893	487	162	223	1354	2657
	(LOW)	(934)	(1417)	(595)	(325)	(108)	(149)	(903)	(1771)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Niagara

IN-NEED POPULATION: 21600 DEMAND POPULATION¹: HIGH 4320 MED 3240 LOW 2160

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1715)	(2601)	(1093)	(596)	(199)	(273)	(1656)	(3251)
	MED	1286	1950	820	447	149	205	1242	2438
	(LOW)	(857)	(1300)	(546)	(298)	(99)	(136)	(828)	(1625)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Wellington-Dufferin

IN-NEED POPULATION: 8580 DEMAND POPULATION¹: HIGH 1716 MED 1287 LOW 858

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(681)	(1033)	(434)	(237)	(79)	(108)	(658)	(1291)
	MED	511	775	326	178	59	81	493	968
	(LOW)	(341)	(516)	(217)	(118)	(39)	(54)	(329)	(646)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Halton

IN-NEED POPULATION: 14090 DEMAND POPULATION¹: HIGH 2818 MED 2113 LOW 1409

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1119)	(1696)	(713)	(389)	(130)	(178)	(1081)	(2121)
	MED	839	1272	535	292	97	134	810	1590
	(LOW)	(559)	(848)	(356)	(194)	(65)	(89)	(540)	(1060)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Peel Region

IN-NEED POPULATION: 25880 DEMAND POPULATION¹: HIGH 5176 MED 3882 LOW 2588

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(2055)	(3116)	(1309)	(714)	(238)	(327)	(1985)	(3895)
	MED	1541	2337	982	536	178	245	1488	2921
	(LOW)	(1027)	(1558)	(655)	(357)	(119)	(164)	(992)	(1947)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Simcoe

IN-NEED POPULATION: 17330 DEMAND POPULATION¹: HIGH 3466 MED 2600 LOW 1733

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1376)	(2086)	(887)	(478)	(159)	(219)	(1329)	(2608)
	MED	1032	1565	658	359	120	164	997	1956
	(LOW)	(688)	(1043)	(438)	(239)	(80)	(110)	(664)	(1304)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Etobicoke

IN-NEED POPULATION: 17560 DEMAND POPULATION¹: HIGH 3512 MED 2634 LOW 1756

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1394)	(2114)	(888)	(485)	(161)	(222)	(1347)	(2643)
	MED	1046	1586	666	364	121	166	1010	1982
	(LOW)	(687)	(1057)	(444)	(242)	(81)	(111)	(673)	(1321)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: York

IN-NEED POPULATION: 8090 DEMAND POPULATION¹: HIGH 1618 MED 1213 LOW 809

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(642)	(974)	(409)	(223)	(74)	(102)	(620)	(1218)
	MED	482	730	307	167	56	77	465	913
	(LOW)	(321)	(487)	(205)	(112)	(37)	(51)	(310)	(609)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: City of Toronto

IN-NEED POPULATION: 37700 DEMAND POPULATION¹: HIGH 7540 MED 5655 LOW 3770

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(2993)	(4539)	(1907)	(1040)	(347)	(477)	(2891)	(5674)
	MED	2245	3404	1430	780	260	357	2168	4255
	(LOW)	(1497)	(2269)	(954)	(520)	(173)	(238)	(1446)	(2837)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: North York

IN-NEED POPULATION: 33130 DEMAND POPULATION¹: HIGH 6626 MED 4969 LOW 3313

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(2630)	(3989)	(1676)	(914)	(305)	(419)	(2541)	(4986)
	MED	1973	2992	1257	686	229	314	1905	3739
	(LOW)	(1315)	(1994)	(838)	(457)	(152)	(209)	(1270)	(2493)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Scarborough

IN-NEED POPULATION: 25710 DEMAND POPULATION¹: HIGH 5142 MED 3856 LOW 2571

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(2041)	(3095)	(1301)	(709)	(236)	(325)	(1972)	(3869)
	MED	1531	2321	975	532	177	244	1479	2902
	(LOW)	(1021)	(1548)	(650)	(355)	(118)	(163)	(986)	(1934)
ESTIMATED SUPPLY									
NET NEED									
	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: East York

IN-NEED POPULATION: 6360 DEMAND POPULATION¹: HIGH 1272 MED 954 LOW 636

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(505)	(766)	(322)	(175)	(58)	(80)	(488)	(957)
	MED	379	574	241	132	44	60	366	718
	(LOW)	(252)	(383)	(161)	(88)	(29)	(40)	(244)	(479)
ESTIMATED SUPPLY									
NET NEED									
	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: York Region

IN-NEED POPULATION: 12450 DEMAND POPULATION¹: HIGH 2490 MED 1867 LOW 1245

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(988)	(1500)	(630)	(344)	(114)	(157)	(955)	(1874)
	MED	741	1124	472	258	86	118	716	1405
	(LOW)	(494)	(749)	(315)	(172)	(57)	(79)	(477)	(937)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Durham

IN-NEED POPULATION: 16430 DEMAND POPULATION¹: HIGH 3286 MED 2464 LOW 1643

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1304)	(1978)	(831)	(453)	(151)	(208)	(1260)	(2473)
	MED	978	1484	623	340	113	156	945	1854
	(LOW)	(652)	(989)	(416)	(227)	(76)	(104)	(630)	(1236)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Muskoka

IN-NEED POPULATION: 5340 DEMAND POPULATION¹: HIGH 1068 MED 801 LOW 534

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(424)	(643)	(270)	(147)	(49)	(67)	(409)	(804)
	MED	318	482	203	110	37	51	307	603
	(LOW)	(212)	(321)	(135)	(74)	(25)	(34)	(205)	(402)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Haliburton, Kawartha, Pine Ridge

IN-NEED POPULATION: 15900 DEMAND POPULATION¹: HIGH 3180 MED 2385 LOW 1590

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1262)	(1914)	(804)	(439)	(146)	(201)	(1219)	(2393)
	MED	947	1436	603	329	110	151	914	1795
	(LOW)	(631)	(957)	(402)	(219)	(73)	(100)	(610)	(1196)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Hastings, Prince Edward

IN-NEED POPULATION: 8510 DEMAND POPULATION¹: HIGH 1702 MED 1276 LOW 851

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(676)	(1025)	(430)	(235)	(78)	(108)	(653)	(1281)
	MED	507	768	323	176	59	81	489	961
	(LOW)	(338)	(512)	(215)	(117)	(39)	(54)	(326)	(640)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Frontenac, Lennox, & Addington

IN-NEED POPULATION: 9810 DEMAND POPULATION¹: HIGH 1962 MED 1471 LOW 981

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(779)	(1181)	(496)	(271)	(90)	(124)	(752)	(1476)
	MED	584	886	372	203	68	93	564	1107
	(LOW)	(389)	(591)	(248)	(135)	(45)	(62)	(376)	(738)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Lanark, Leeds, & Grenville

IN-NEED POPULATION: 7740 DEMAND POPULATION¹: HIGH 1548 MED 1161 LOW 774

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(615)	(932)	(392)	(214)	(71)	(98)	(594)	(1165)
	MED	461	699	294	160	53	73	445	874
	(LOW)	(307)	(466)	(196)	(107)	(36)	(49)	(297)	(582)
ESTIMATED SUPPLY									
NET NEED									
	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Ottawa-Carleton

IN-NEED POPULATION: 32370 DEMAND POPULATION¹: HIGH 6474 MED 4855 LOW 3237

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(2570)	(3897)	(1638)	(893)	(298)	(409)	(2482)	(4872)
	MED	1928	2923	1228	670	223	307	1862	3654
	(LOW)	(1285)	(1949)	(819)	(447)	(149)	(205)	(1241)	(2436)
ESTIMATED SUPPLY									
NET NEED									
	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Seaway Valley

IN-NEED POPULATION: 7250 DEMAND POPULATION¹: HIGH 1450 MED 1087 LOW 725

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(576)	(873)	(367)	(200)	(67)	(92)	(556)	(1091)
	MED	432	655	275	150	50	69	417	818
	(LOW)	(288)	(436)	(183)	(100)	(33)	(46)	(278)	(546)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Renfrew

IN-NEED POPULATION: 6060 DEMAND POPULATION¹: HIGH 1212 MED 909 LOW 606

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(481)	(730)	(307)	(167)	(56)	(77)	(465)	(912)
	MED	361	547	230	125	42	57	348	684
	(LOW)	(240)	(365)	(153)	(84)	(28)	(38)	(232)	(456)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Parry Sound

IN-NEED POPULATION: 2990 DEMAND POPULATION¹: HIGH 598 MED 448 LOW 299

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(237)	(360)	(151)	(82)	(27)	(38)	(229)	(450)
	MED	178	270	113	62	21	28	172	337
	(LOW)	(119)	(180)	(76)	(41)	(14)	(19)	(115)	(225)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Timiskaming-Nipissing

IN-NEED POPULATION: 7640 DEMAND POPULATION¹: HIGH 1528 MED 1146 LOW 764

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(607)	(920)	(386)	(211)	(70)	(97)	(586)	(1150)
	MED	455	690	290	158	53	72	439	862
	(LOW)	(303)	(460)	(193)	(105)	(35)	(48)	(293)	(575)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Sudbury-Manitoulin

IN-NEED POPULATION: 13335 DEMAND POPULATION¹: HIGH 2667 MED 2000 LOW 1334

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(1059)	(1606)	(675)	(368)	(123)	(169)	(1023)	(2007)
	MED	794	1204	506	276	92	127	767	1505
	(LOW)	(529)	(803)	(337)	(184)	(61)	(84)	(511)	(1003)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: North Cochrane

IN-NEED POPULATION: 2800 DEMAND POPULATION¹: HIGH 560 MED 420 LOW 280

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(222)	(337)	(142)	(77)	(26)	(35)	(215)	(421)
	MED	167	253	106	58	19	27	161	316
	(LOW)	(111)	(169)	(71)	(39)	(13)	(18)	(107)	(211)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: South Cochrane

IN-NEED POPULATION: 3640 DEMAND POPULATION¹: HIGH 728 MED 546 LOW 364

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(289)	(438)	(184)	(100)	(34)	(46)	(279)	(548)
	MED	217	329	138	75	25	35	209	411
	(LOW)	(145)	(219)	(92)	(50)	(17)	(23)	(140)	(274)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Algoma

IN-NEED POPULATION: 8780 DEMAND POPULATION¹: HIGH 1756 MED 1317 LOW 878

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(697)	(1057)	(444)	(242)	(81)	(111)	(673)	(1321)
	MED	523	793	333	182	61	83	505	991
	(LOW)	(349)	(529)	(222)	(121)	(40)	(55)	(337)	(661)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Kenora-Rainy River

IN-NEED POPULATION: 7420 DEMAND POPULATION¹: HIGH 1484 MED 1113 LOW 742

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(589)	(893)	(375)	(205)	(68)	(94)	(569)	(1117)
	MED	442	670	281	154	51	70	427	838
	(LOW)	(295)	(447)	(188)	(102)	(34)	(47)	(285)	(558)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Thunder Bay

IN-NEED POPULATION: 11740 DEMAND POPULATION¹: HIGH 2348 MED 1761 LOW 1174

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(932)	(1413)	(594)	(324)	(108)	(148)	(900)	(1767)
	MED	699	1060	445	243	81	111	675	1325
	(LOW)	(466)	(707)	(297)	(162)	(54)	(74)	(450)	(883)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

ADDICTION PLANNING AREA: Province of Ontario

IN-NEED POPULATION: 516840 DEMAND POPULATION¹: HIGH 103368 MED 77526 LOW 51684

		DETOX	ASSESSMENT	OUTPATIENT	DAY TREATMENT	SHORT-TERM RESIDENTIAL	LONG-TERM RESIDENTIAL	AFTERCARE	CASE MANAGEMENT
ESTIMATED CAPACITY GUIDELINE	(HIGH)	(41037)	(62227)	(26148)	(14263)	(4754)	(6534)	(39636)	(77784)
	MED	30778	46670	19611	10697	3566	4900	29727	58338
	(LOW)	(20518)	(31114)	(13074)	(7131)	(2377)	(3267)	(19818)	(38892)
ESTIMATED SUPPLY									
NET NEED	(HIGH)								
	MED								
	(LOW)								

¹ HIGH, MEDIUM AND LOW ESTIMATES CORRESPOND TO THE ESTIMATE OF THE DEMAND POPULATION BASED ON 20%, 15% OR 10% OF THE IN-NEED POPULATION, RESPECTIVELY. THE MEDIUM ESTIMATES ARE RECOMMENDED FOR USE IN MOST PLANNING JURISDICTIONS.

